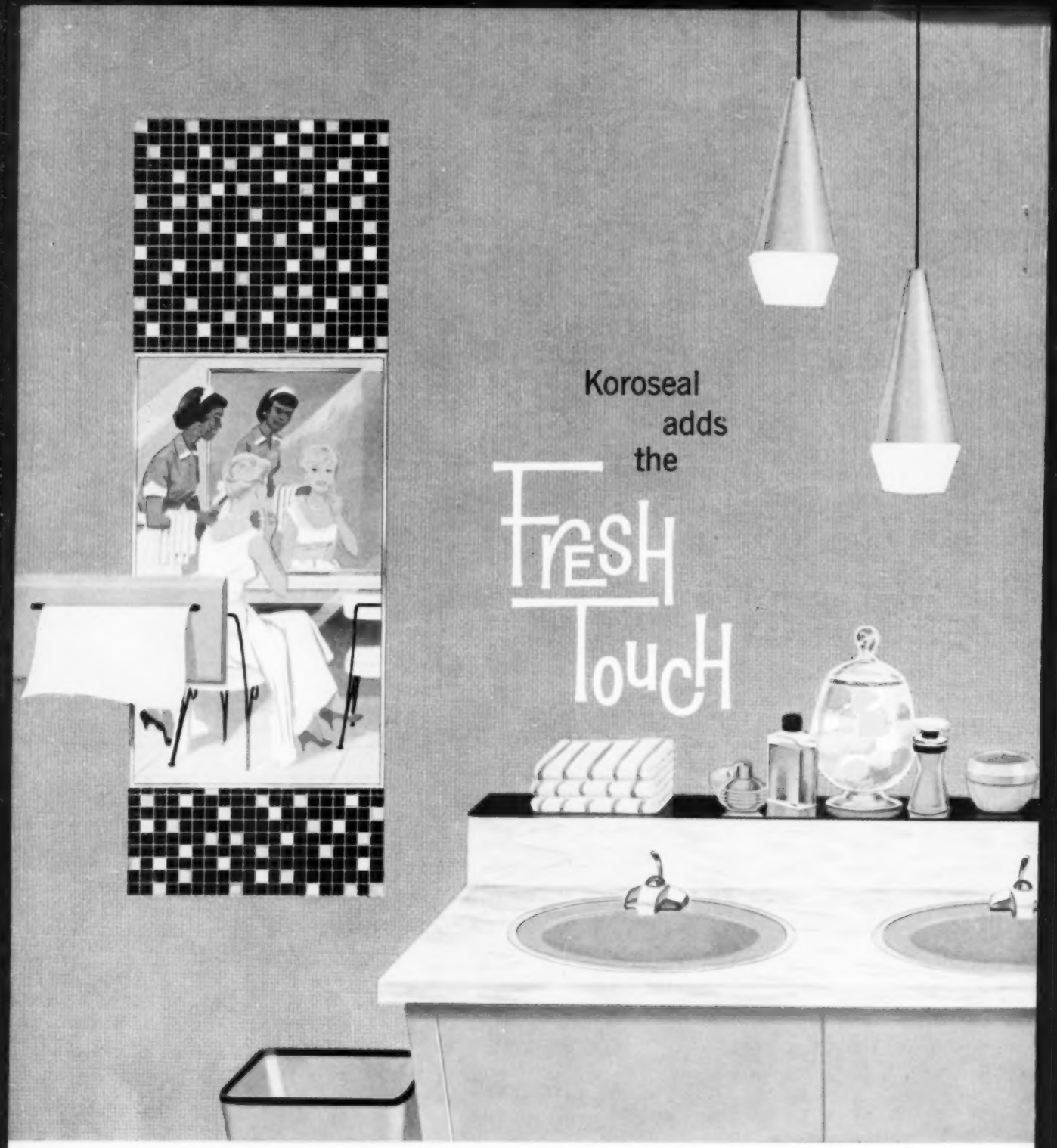
The Modern Hospital

JULY 1960

PATIENTS VOTE FOR PROGRESSIVE CARE

(Page 75)



Use of light, cheerful colors and materials that are practically maintenance-free is a major trend in modern institutional rest room decor. Koroseal fabric-backed vinyl wall coverings by B.F.Goodrich meet both demands, and at comparatively low cost. Notice above how the freshness of Koroseal's *Linen Weave* pattern blends with other commonly used rest room materials—ceramic tile, metal, porcelain and marble. There's a Koroseal color to fit into any color scheme. *Linen Weave*, for example, comes in 20 pastel shades. All Koroseal wall coverings are washable with soap and water, retain their sparkling beauty for years.

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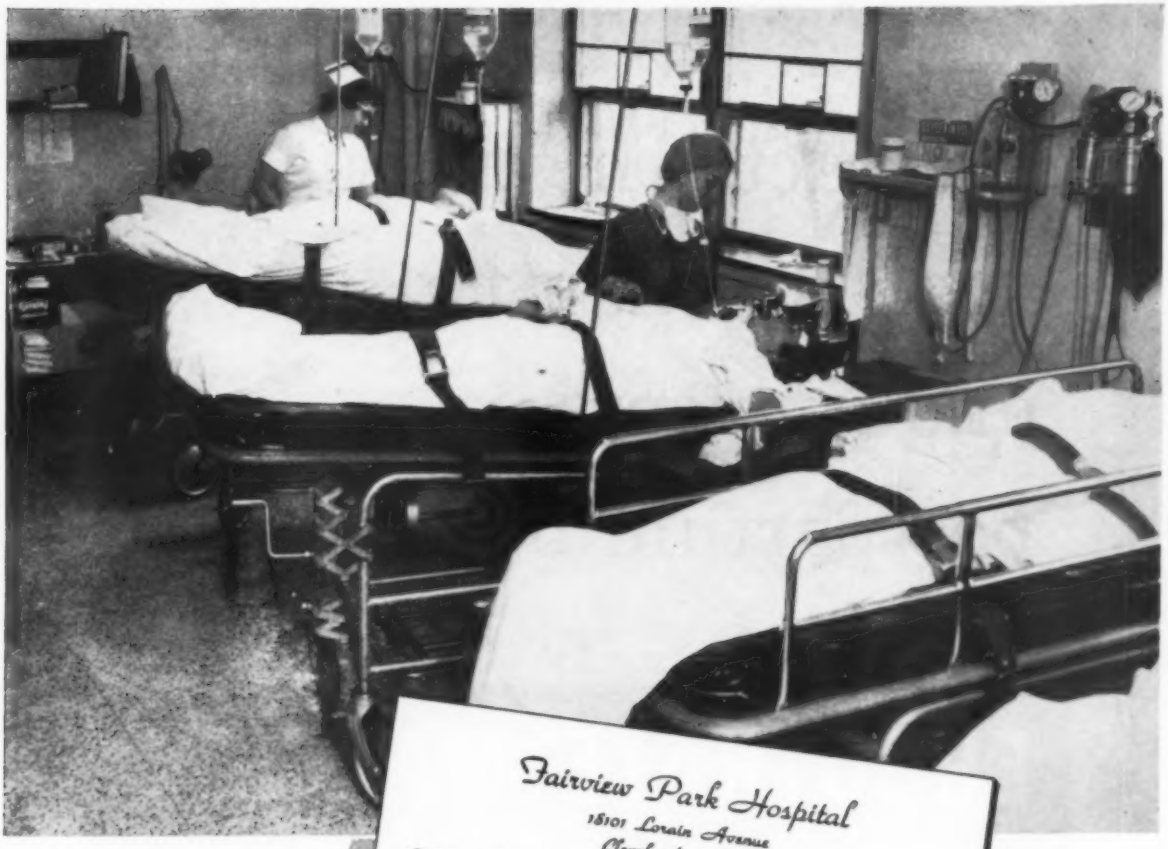

Modern Fairview Park Hospital, Cleveland, uses HAUSTED Easy Lift wheel stretchers exclusively in their Recovery Room and Emergency Room. Mr. V. D. Seifert, Administrator, tells why in his letter.

Fairview Park Hospital
15101 Lorain Avenue
Cleveland 11, Ohio

Office of the Administrator

Clearwater 2-1222

Fairview Park Hospital formerly used beds in the Recovery Room. We now use Hausted Easy Lift slide and tilt stretchers exclusively for several reasons. First is their easy maneuverability - no longer do we scratch and mar corridor walls and door jambs. The added safety of the large, conductive casters is important, too. Also the convenience of the many useful accessories appeals to us. We now can accommodate more patients in the Recovery Room without crowding.

Administrator

For complete information on HAUSTED hospital equipment, write

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SIMMONS COMPANY
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For additional information, use postcard facing back cover.

The Modern Hospital

JULY 1960 VOLUME 95, NO. 1

Continued on next page ▶

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The Modern Hospital

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READER OPINION

Surgeon Takes Dim View of TV Operation

One of the most astonishing public exhibitions of make-believe surgery occurred on television on Monday evening, May 9, 1960, at 7:30 p.m., C.D.T. This took place on the program known as "Bourbon Street Beat," and it must be mentioned, if for no other reason than to assure the laity that what they saw that night bears no resemblance to an operation in a modern hospital operating room.

The plot of the drama concerned a planned escape from a boys' reformatory with the infirmary surgeon as a hostage. This much could be comprehended and seemed logical, but it was in the implementation of this plan that the play came unstuck. Apparently, simulated disease, in the form of acute appendicitis, was to be the vehicle by which the prison physician, described variously as "the best doctor the prison ever had" and as "a mighty good surgeon," was to be maneuvered into a position in which a nonsurgical scalpel, called a "shiv," might be used to obtain his cooperation in the escape.

The need to simulate acute appendicitis is obscure, for the surgeon was obviously convinced that his recalcitrant patient had the real thing. In fact, he had been following the boy's blood count and had him loaded with antibiotics. Moreover, he openly announced to the patient that, if this didn't cure his appendicitis, he would have to operate.

Obviously, there must have been some doubt in the patient's mind as to the judgment of his surgeon, for he had been boning up for days from the doctor's medical books on the signs and symptoms of appendicitis and, true to television form, he sprang the bogus bellyache at the opportune moment. The surgeon was trapped, and his future seemed somewhat uncertain at this point.

However, nature conveniently intervened; the patient fell to the floor in anguish, and, with a swift palpation of the right lower quadrant, the surgeon announced that "the appendix had burst." There followed a rather confusing interlude in which the patient's accomplices, also armed with "shivs," were persuaded reluctantly that surgery was imperative. For this, they granted a maximum of 45 minutes, but refused to grant a move to the prison hospital. This meant that the infirmary dispensary must suffice for the surgery. But now, the surgeon must be persuaded not to abandon his patient. This was accomplished by a winsome nurse, also a hostage, and obviously his only available assistant.

Fortunately, the dispensary was well equipped with an operating table, adequate surgical lights, and an abundant supply of instruments. It was also glass-enclosed, which permitted close scrutiny of all that transpired. Into view came the patient, comfortably flat on the table. The surgeon, having finished his scrub, was assisted into his rubber gloves by the nurse and assumed his stance at the table. It might be mentioned that he was not gowned, nor was the nurse. The surgeon commanded, "Anesthesia, nurse," and in her hand appeared a syringe full of a colorless fluid, the final destina-

tion of which was not explained. Was it procaine for local infiltration of the abdomen? Was it thiopental sodium for intravenous administration? Was it an anesthetic for the spinal canal? We can only guess that it was not a local infiltration, for the patient's placid face belied this method of pain relief. We doubt that it was an intravenous anesthetic, for the patient could well have swallowed his tongue for all the attention anyone paid to him. We wonder if it was spinal anesthesia, for he remained perfectly flat on the table, and there was no demonstrable effort to establish a satisfactory level of anesthesia.

Of course, we know all this, because during the operation the patient remained unmasked and unseparated from the operating field. For all we know, he exhaled a substantial number of staphylococci into his wound, thus increasing the bacteria so plentifully introduced by the surgeon and the nurse.

But how was the surgeon faring? He was perplexed; moreover, he was perspiring, and well he might, for his only assistant, the winsome nurse, was situated directly beside him, and, from the close-ups, was more concerned with pounding instruments into his hand than in providing exposure and assistance. The surgeon cried out, "Blood pressure, nurse," and, to our amazement, her hand left the sterile field and fastened itself upon the sphygmomanometer. This recorded a falling blood pressure for which nothing was done, and, as a matter of fact, nothing could be done by two people elbow-deep in surgery.

The nurse's hand returned to her sterile instruments, and then was next seen to mop the surgeon's sweating brow. This apparently did the trick, for he finished the operation, although not within the prescribed time limit of 45 minutes.

Meanwhile, the bearers of the "shivs" stood entranced before this dramatic scene. In fact, it was apparent that they were not capable of further detaining action, and they were quickly overpowered by the hostages.

The drama was brought to a fitting climax during the patient's convalescence. Happily, he decided that his attitude had been wrong, and the warden granted him amnesty from something called "maximum security."

This suggests, of course, that appendectomy is a cure for criminality and this could be the subject for a bit of medical research. It also raises the question as to whether surgeons and hospitals have been devoting too much pomp and circumstance to procedures in the operating room. — ROBERT S. MYERS, M.D., *executive assistant director, American College of Surgeons, Chicago.*

Sell Students on Nursing

Sirs:

After reading Mr. Rankin's excellent article on male nurses I want to say that the article is 25 years behind the times. The idea should have been put before high school students years ago.

Representatives should speak to all junior and senior students. That way those interested in medicine who could not afford complete studies or make the grade could change courses to fit this nursing requirement.

Mrs. William S. Weaver
Philadelphia

For additional information, use postcard facing back cover.

ROVING REPORTER

Employes Are Served Fellowship With Luncheon

Employes were given a chance to eat with and meet with the administrator at Clara Maass Memorial Hospital, Belleville, N.J.

Groups of 15 employes at a time were invited to the series of special luncheons. As guests were selected on an alphabetical, rather than departmental, basis, the luncheons have also helped interdepartmental relations.

After the luncheon, served by the dietary employes, all employes were asked to introduce themselves, explain their positions, and tell how long they had been with the hospital.

The administrator, Albin H. Oberg, then explained the operations of the hospital, its organization and management, and the relationship between the department heads and the administrator and the department heads and employes. Special emphasis was placed on patient relations and the employe as a hospital representative — regardless of his position.

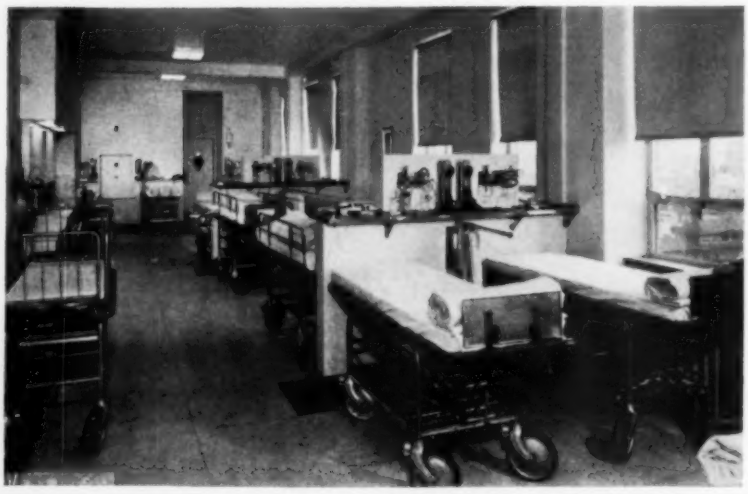
The importance of the individual employe in the hospital program was stressed. Employes were encouraged to bring their suggestions and problems to the attention of their department heads.

The first luncheon guests were skeptical and reserved and conversation was at first limited, Mr. Oberg reported. After the welcome and explanation they relaxed, and after the first month employes were asking for invitations, he said.

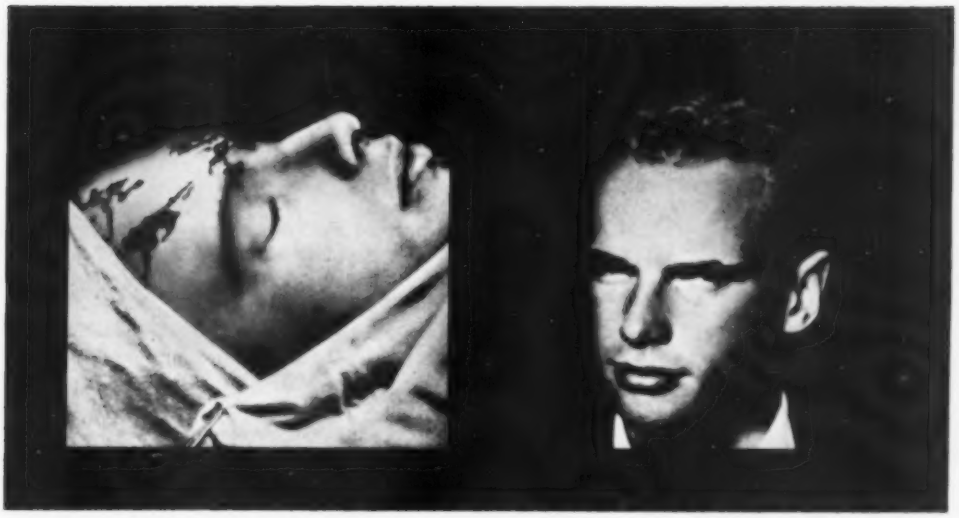
The major drawback to this type of program, according to the administrator, is the time required to set up the schedule, check to make sure the employe will be on duty, and type the invitations. It is also important to keep other administrative appointments from interfering with the luncheon day. At Clara Maass, approximately 30 weeks were required to cover the entire full-time staff.

It has been worth the time and effort, however, Mr. Oberg feels. "The employes, through dining with one another, now have a better understanding of other departments and the people they work with. In addition, a clearer understanding has developed concerning their relationship in the total patient-care program."

Doctors' Dollars Help Patients Wake Up



This new postanesthesia room at St. John's Hospital, Springfield, Ill., is a gift from the doctors themselves. The administration believes that the room is especially valuable because it makes the anesthesia staff and equipment more readily available after surgery and concentrates nursing care, thus lessening the duties of the floor nurse. The special room also spares relatives the anxiety of watching the unconscious or semiconscious anesthetized patient.



from the film: SURGICAL REPAIR OF FACIAL LACERATIONS FOR OPTIMUM COSMETIC RESULTS. C. P. Vallis, M.D., Tufts Medical School and Lynn Hospital, Lynn, Mass. 16 mm., color, sound, 20 min. (Obtainable from Paul F. MacLeod, M.D., Medical Director, Eaton Laboratories, Norwich, New York.)

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As Power To Heal Increases, So Does Public Disenchantment

By Gordon Davis

THE editorial page of the morning newspaper comments at column length on the public bitterness toward the medical profession displayed at a recent hearing on Blue Shield subscriber rates.


Gordon Davis

It was alarming, the editorial writer said, to observe that "the hearing rooms were filled with people willing to believe that physicians, en masse, were selfish, greedy and sometimes not even above cheating.

"Justifiedly or not, the image of the doctor in America has changed for the worse."

And, it might have been added, so has that of the hospital.

It is difficult to be objective about this touchy subject. The dedication of our health leaders — doctors and hospital administrators — surely is no less than it has ever been. Their power to heal is infinitely greater. It hurts to see public adoration changing to skepticism and disillusionment.

And yet this problem exists. It is certain to give birth to state medicine if uncorrected. It cannot be solved except by doctors and hospitals themselves. Public relations people can help, but not until the star players have decided to take action.

How?

Well, it would help if the diehards did not, at the first sign of criticism, retreat into those sedate sanctums where the hoarse shouts of *hoi polloi* never penetrate. The "let 'em eat cake" posture invites an ultimately violent fate.

The constructive course is to try to find the answers to questions no one has fully investigated as yet.

Why are the people mad? Is it because health care costs so much? Is it because they don't understand the cost? Is it something deeper? Do they feel that they are not treated well? Do they feel that they must dance to the tune called by hospitals and doctors, instead of the other way around? Is it that doctors and hospitals, once meek as they faced disease helplessly, have lost humility because of their scientific conquests? Or is it just that they no longer bother with back-rubbing, hand-holding, and tongue-clucking?

But I'm not so sure that the answers are as important as the effort to find them. Not too many hospitals and doctors give evidence of caring how the patient or the public feels. It isn't exactly a case of "cure 'em and kick 'em out." It's more like preoccupation — concern with pathology instead of person.

The emotional stresses besetting patients, their small whims and prejudices and peeves, are treated as if they are beneath notice, like the temper tantrums of small children. This is an excellent way to make a mad patient madder.

In other words, medical and hospital science continues its spectacular progress, and we are so fascinated that we pitch our dearest amenities on the ash heap as if they were obsolete. True or false?

Before answering, ask yourself whether you have spent as much effort to improve patient relations in your hospital as you have to improve physical facilities. ■

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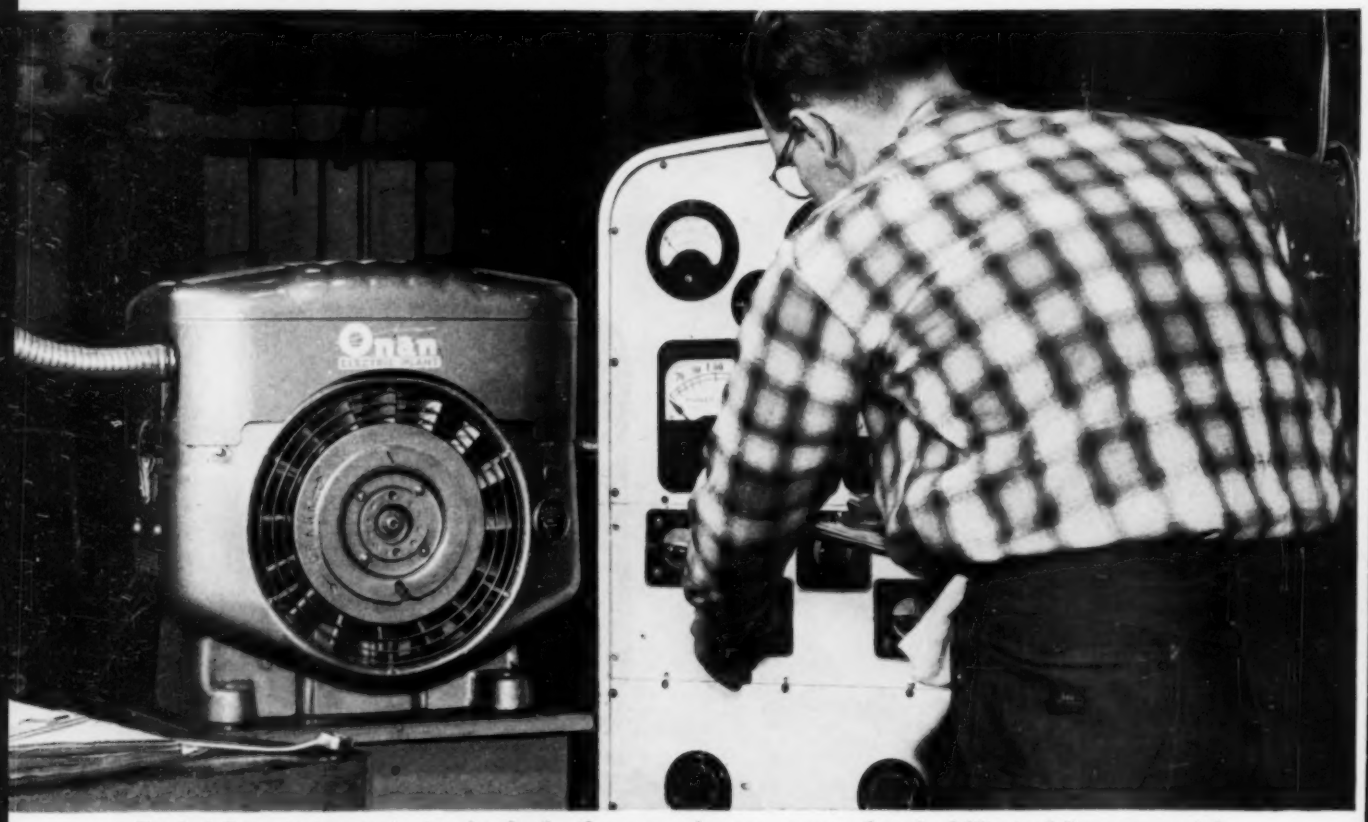

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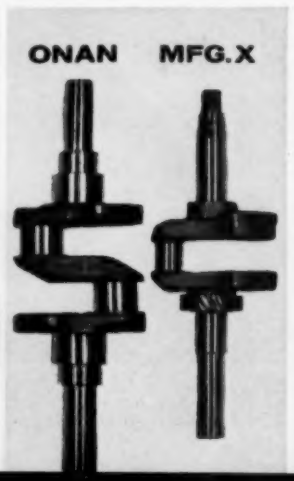

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ALBERT A. LOGEFEIL
Chief of Plant Operations
BROOKSIDE HOSPITAL
San Pablo, California

"The close cooperation of OTIS, the architects and the administration of BROOKSIDE HOSPITAL illustrates how well a job can be done when everyone concerned works together, aware of one another's problems," says ALBERT LOGEFEIL, Chief of Plant Operations.

"Our hospital was completed in 1954. In 1956, because of the community's growth, it was decided to increase our capacity from 165 to 246 beds by adding a seventh floor and completing the unfinished sixth floor.

"This was the elevator situation at the start: There were three hoistways but only two OTIS Elevators. The third hoistway having been installed with expansion in mind.

"This was the modernization procedure: Two elevators had to be in operation at all times to provide the normal passenger and staff service and handle traffic to the first floor surgery. In addition, these elevators had to distribute the food normally handled by dumbwaiters. And use of the elevators for construction purposes or by OTIS personnel was taboo.

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"During construction of the two additional floors and the elevator penthouse, temporary but substantial tape-sealed housings were necessary to protect the machinery of the two running elevators from debris and dust.

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"Time of modernization? Seven months.

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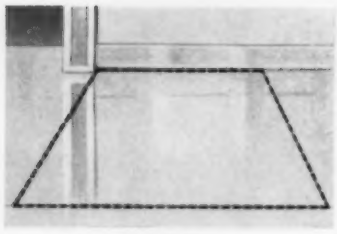

FIGURE 1

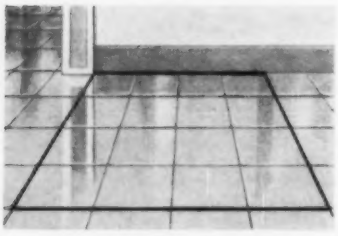

FIGURE 2

If you were a "staph" germ, where would you hide?

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1. Rainier, W. G., and Lee, B.: Hospitals, Jan. 1, 1957. 2. Kehlmann, W. H.: Med. Hosp. 84:104, May, 1955.
3. Hellman, L. D.: To be published.

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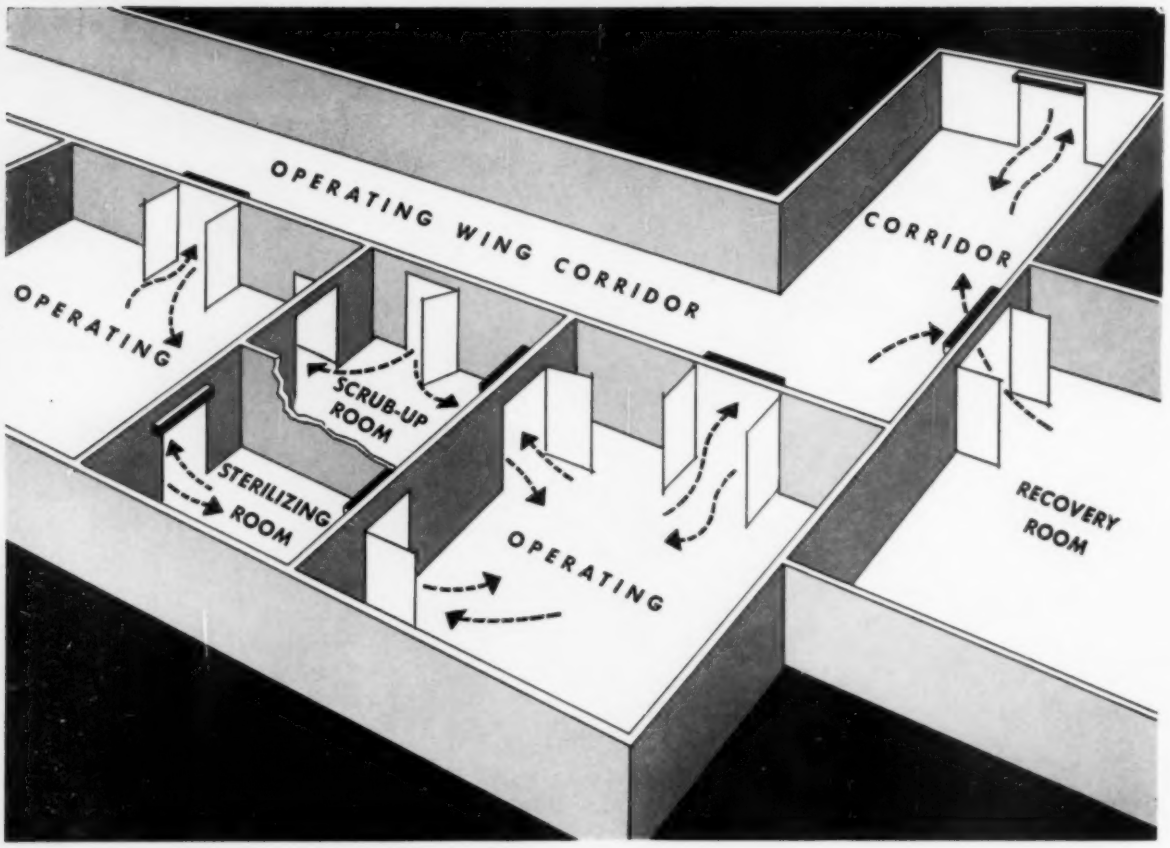

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HARDWARE / AUTOMATIC DOOR EQUIPMENT / ALUMINUM WINDOWS

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This famous trademark distinguishes over 20,000 quality products of The Stanley Works, New Britain, Conn.—hand tools • electric tools • builders hardware • industrial hardware • drapery hardware • automatic door controls • aluminum windows • stampings • springs • coatings • strip steel • steel strapping—made in 24 plants in the United States, Canada, England and Germany.

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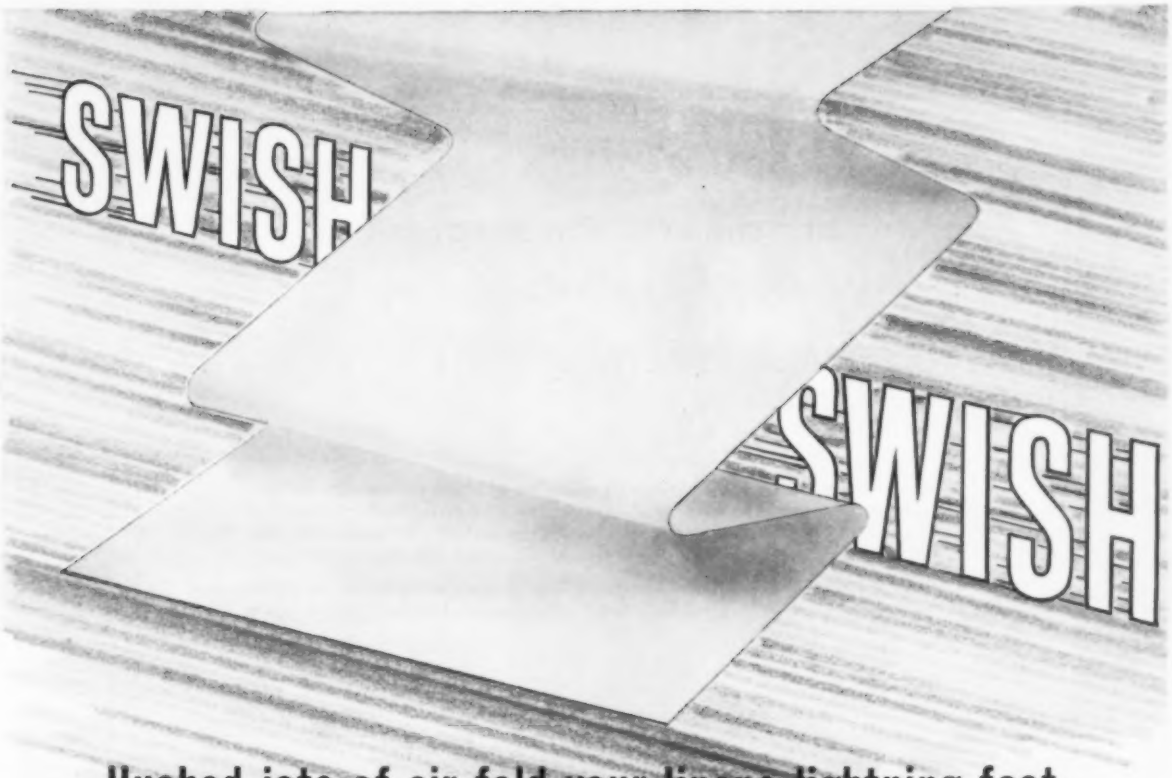

Hushed jets of air fold your linens lightning fast

TROY FLEXIMATIC® Air Jet® Folder . . . the one and only folder that handles your linens with care using powerful jets of air.

In comparison with blade folders, TROY FLEXIMATICS . . . and only FLEXIMATICS . . . can provide the lightning fast, positive folding done by hushed jets of air . . . eliminating the clank-and-clatter of outdated mechanical folding.

Only TROY FLEXIMATICS can perform half *and* quarter folding. Blade folders can make only quarter folds, so all half folding must be done by hand.

TROY FLEXIMATIC Folding Controllers *automatically* measure linens from towel size to double bed size, calculate the location of the two folds, and direct the air jet folding. This automatic operation replaces three receivers and folders.

TROY *alone* offers one through six lane folder models so you can perfectly match linen load and folding capacity.

TROY FLEXIMATICS also provide individual lane timing; folding of narrow and wide pieces at random; folding of bib aprons with strings and stacker equipment for small pieces.

Get the complete story on the one and only folder that handles your linens with care using air . . . TROY FLEXIMATIC Air Jet Folder. See your TROY representative or write . . .

Troy® LAUNDRY MACHINERY

DIVISION OF

American Machine and Metals, Inc.

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For additional information, use postcard facing back cover.

ONLY CARRIER OFFERS ICEMAKERS WITH CERTIFIED CAPACITY

There are 16 Carrier ice machines to give you exactly the kind of ice you need, cubes, crushed, flakes or chips. You can be sure you'll get the amount of ice you expect, too, because every Carrier ice machine comes with capacity certified in writing.

There are no "up to" qualifications. There are no "average" production figures. Capacity is determined according to air and water temperatures where you are.

You can save as much as 80% on ice with a Carrier Icemaker. Your Carrier dealer will give you the exact figures—and a lot of other trustworthy facts. Call him. He's listed in the Yellow Pages under Ice Making Equipment. Or, write to Carrier Corporation, Syracuse 1, New York.

Carrier **AIR CONDITIONING • REFRIGERATION**

engine power BY CATERPILLAR

NEW COMPACT DIESEL ENGINES AND ELECTRIC SETS

Announcing a new line of Caterpillar four-cycle Diesels that sharply reduce physical dimensions and weight-to-horsepower ratio. Features of durability, fuel economy and dependability, long associated with Cat four-cycle Diesels, are retained.

- **Four-cycle Premium Performance . . . at No Premium in Price**
- **Excellent Service Life**
- **Turbocharged or Turbocharged-Aftercooled**
- **New Compactness**
- **Less Total Weight**
- **Exceptional Fuel Tolerance**
- **Clean Burning of Fuel**
- **Power-output Ratings Are Realistic, Horsepower or Kilowatt Certification on Request**
- **Available in Industrial, Marine or Electric Set Configurations**

For complete performance specifications on these new Caterpillar Diesels or on the complete line, see your Caterpillar Dealer. Or, write to Engine Division, Caterpillar Tractor Co., Peoria, Illinois, U. S. A. Ask for the catalog on the complete Caterpillar Engine line.

CATERPILLAR

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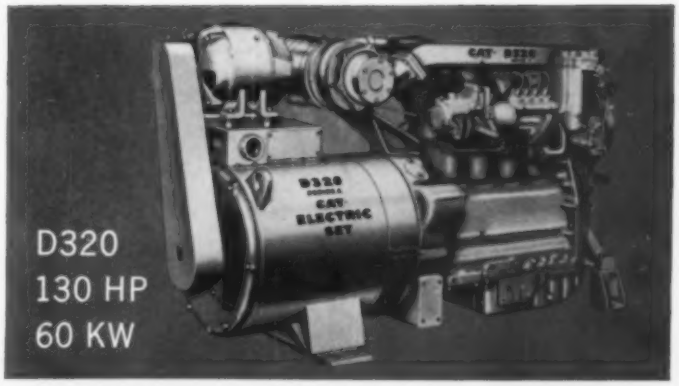

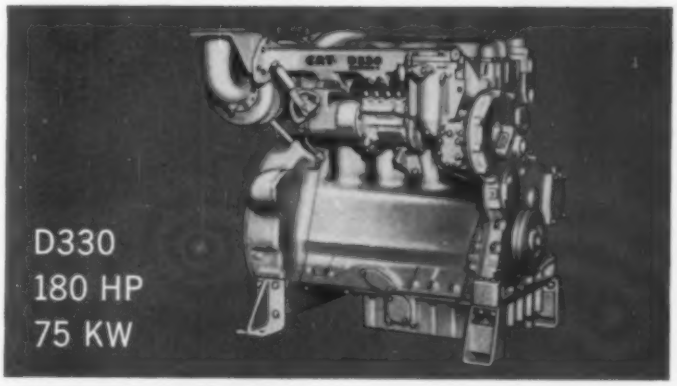

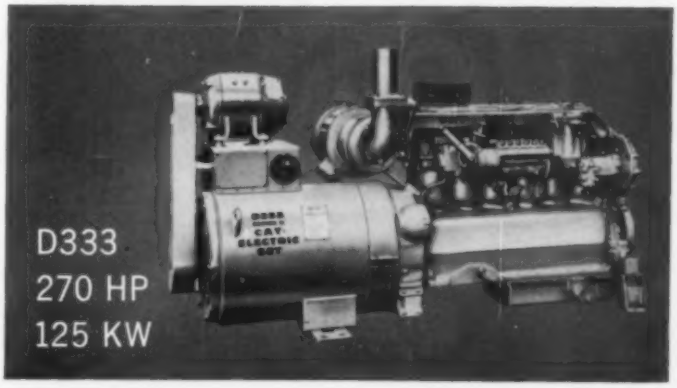

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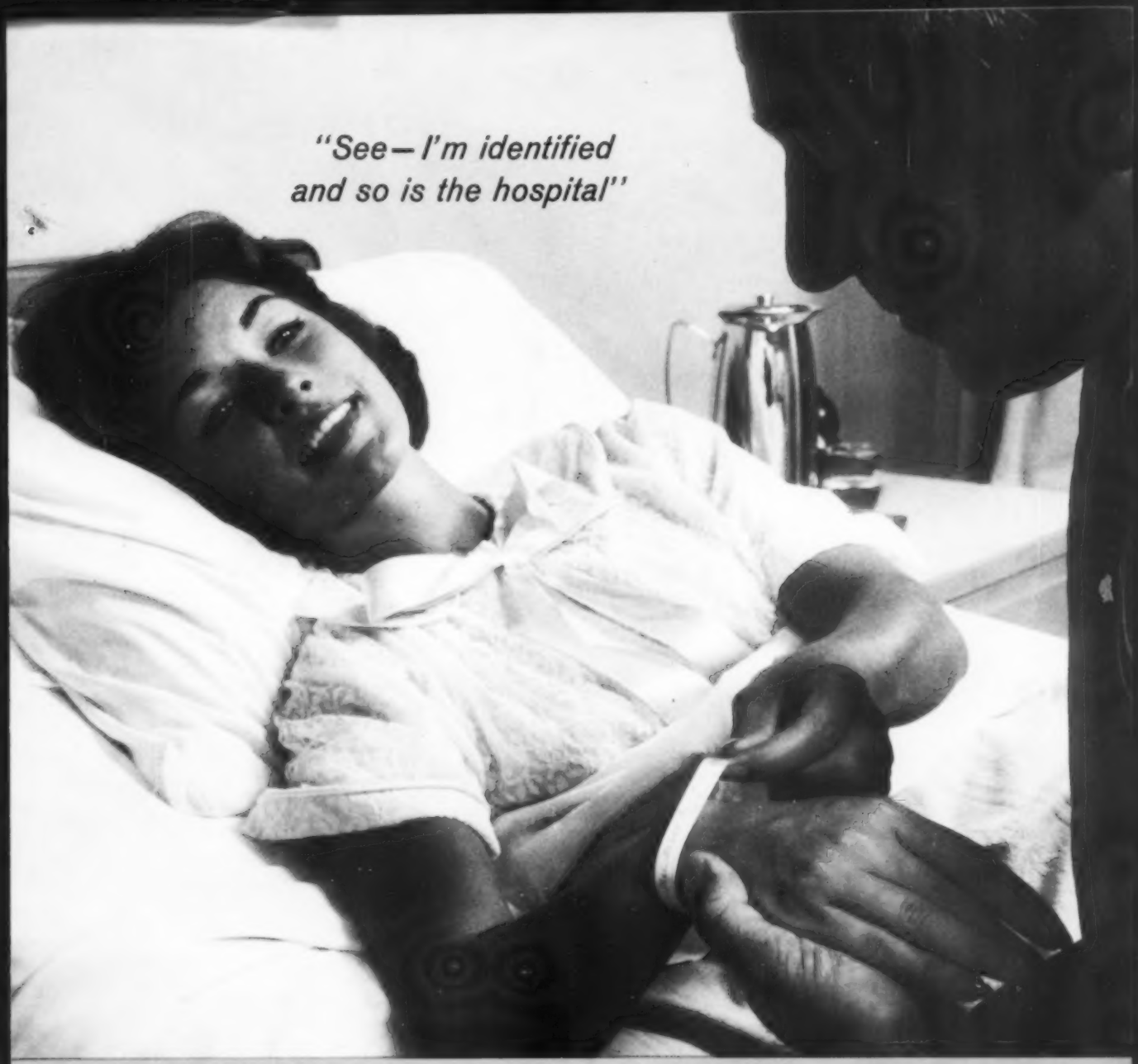

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Ident-A-Band®

identifies your hospital as well as your patients

All the facts are there . . . sealed comfortably and safely around the patient's wrist. All the facts needed to make identification complete. You fill in patient data. And Hollister prints your hospital's name and city inside every Ident-A-Band you use.

Your hospital's name on Ident-A-Band, as on your letterhead, adds dignity and creates confidence. It tells the patient that your hospital stands behind the care it provides.

There's another reason for the hospital imprint, too. It's the logical, final step in positive identification. Your patient is protected in *any* situation—in case of emergency or disaster, in case of tests in outside locations, in case he should become confused and wander away. Full identification, including your hospital's name, accompanies the patient around the clock.

When your hospital's name goes on Ident-A-Band, it goes on the band that offers positive identification plus complete comfort to the patient. For samples and literature, write

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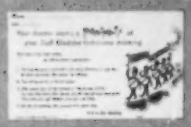

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6 ways to BUILD PATIENT CONFIDENCE

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With a touch of humor, Prep-Cards put your patient's mind at ease . . . before he worries needlessly about those mysterious tests and procedures. Prep-Cards by Hollister prepare the patient by explaining what's in store for him in six routine situations. This helps him relax, promotes his cooperation, makes things easier for your staff. Each card is personalized with your hospital's name.

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Picker Minograph photofluorographic miniature film units in a variety of models for efficient handling of any caseload.

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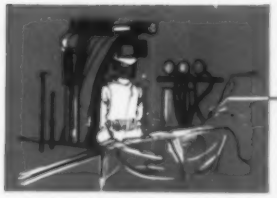
Mobile x-ray units from 15 MA to 300 MA, all sharing proverbial Picker stamina to stand off the hard knocks of mobile service.



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"Roving" Picker x-ray units to serve any room in the O.R. Suite. Or built-in overhead x-ray combined with effective surgical lighting (all explosion-safe and Underwriter-Listed).

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Radiation-measuring instrumentation for thyroid uptake, kidney function and similar tests. Labeled radioactive compounds. Detectors, scalers, ratemeters, counters, for the gamut of research and clinical applications.

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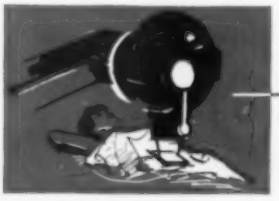
Full range of Picker apparatus for superficial, intermediate, and deep x-ray therapy. All necessary positioning and protective accessories, including room-shielding.



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X-ray, darkroom, therapy, and radioisotope department planning at any level from preliminary rough-ups to finished layouts with full specs. Your local Picker man (a trained expert in his own right) is always at your beck and call.

"we'll come out ahead by turning it all over to Picker" . . .

Thousands of hospitalmen do just that, year after year, on the basis of *proven* advantage. Picker X-Ray sales offices and service depots (always on their toes to serve you) are strategically spotted in principal cities the country over. See your local 'phone book or write Picker X-Ray Corporation, 25 South Broadway, White Plains, New York.

if it has to do with RADIATION | it has to do with Picker x-ray

airkem research

*a new dimension in environmental health**

During the past 20 years modern chemistry has brought about tremendous improvements in environmental sanitation. Some of these have been due to the efforts of the world-wide Airkem organization.

As a leader in this movement, Airkem has proved to sanitation administrators time and again that the cleaning and disinfecting of their buildings does not represent a "complete" job.

A "complete" program requires products with an indispensable ingredient. In addition to performing their major function, they must also contribute to the improvement of the overall environment. Every Airkem product does just that. This applies to A-3, Airkem's combination detergent-disinfectant-odor counteractant — Airkem Insecticides—and Airkem Bowl Cleaner. They bring you a healthier environment and also provide a lasting air-freshened effect.

Also, simple, inexpensive equipment can be provided to control odors in the atmosphere and to improve air quality. This can be achieved through your air conditioning systems or by means of attractive portable units.

We would like to demonstrate to you the many benefits of our complete program. Qualified Airkem distributors, located in key marketing centers of the U.S. and Canada, are ready to serve you. Call your local Airkem representative direct, or send your request to John Hulse, Airkem, Inc.

**The World Health Organization defines "health" as, "not only freedom from disease, but the well-being and comfort of the human being."*

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cuts breakage, replacement costs and assembly time—every plunger fits every clear glass barrel

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provides greater safety through new design features—sharper points, tamper-proof packages, protective sheaths, sure-grasp hubs

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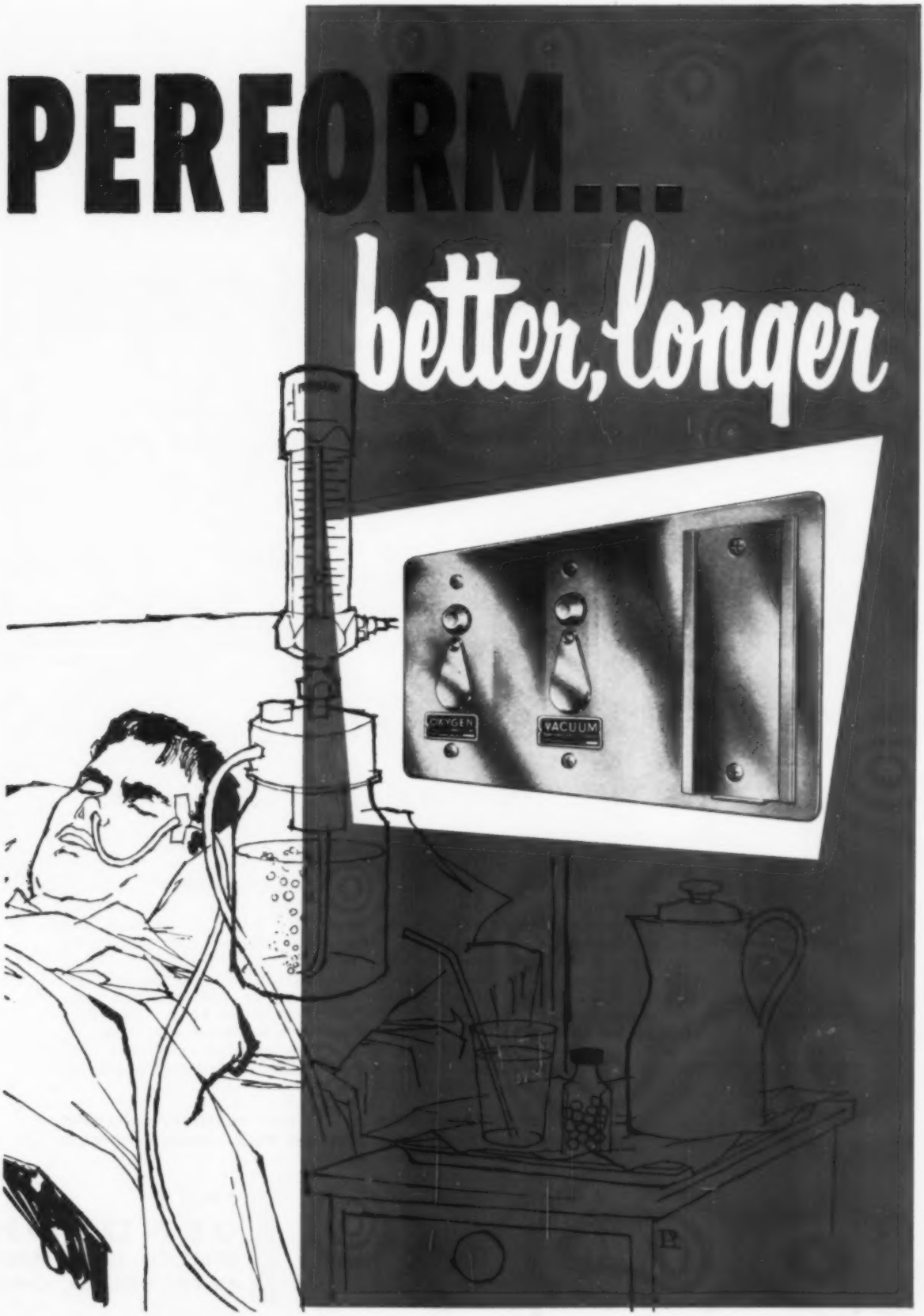

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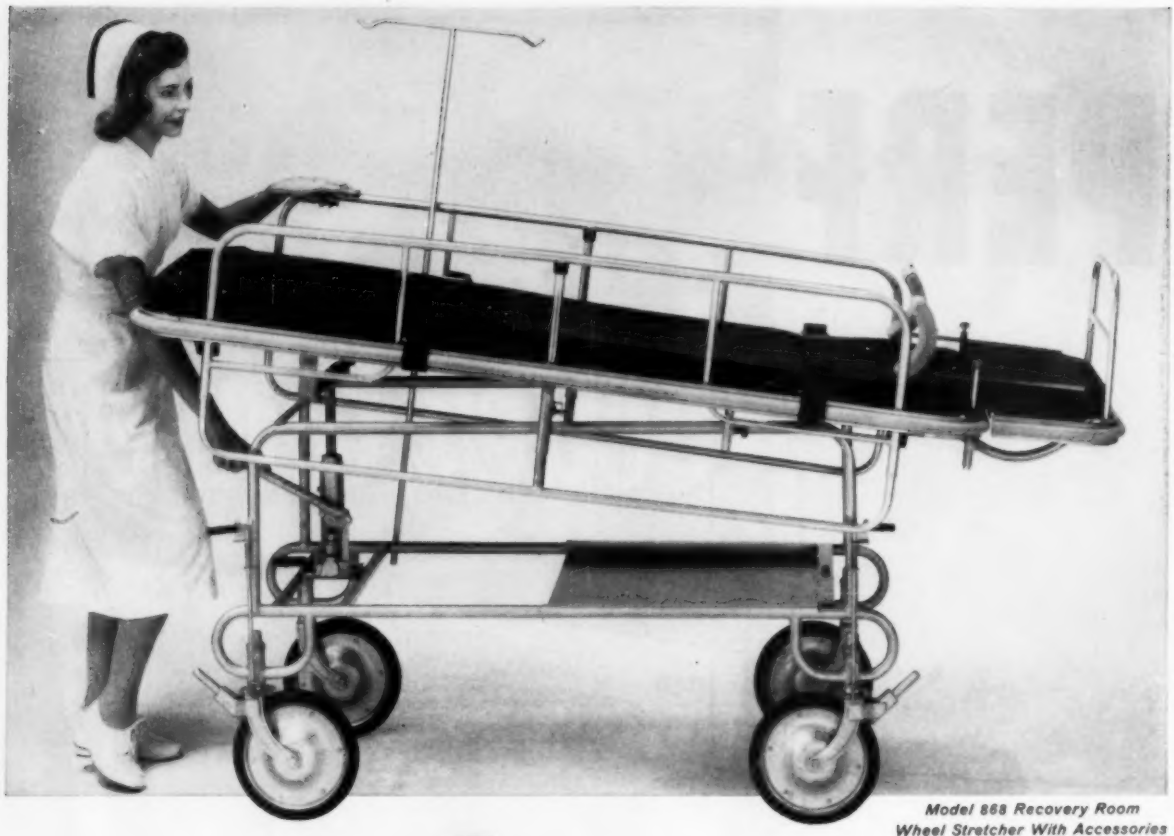


Model 868 Recovery Room Wheel Stretcher With Accessories

IF IT'S A GENUINE *Gendron*

...IT'S THE FINEST OF ITS KIND!

for quality, durability... for assured patient comfort!

The most versatile, new wheel stretcher designed for convenience and protection of the patient. This low cost recovery room wheel stretcher combines all the important features of the standard wheel stretcher with those requirements so necessary in new, hospital recovery rooms. It is equipped with two swivel fork locks, two brakes, blanket shelf and conductive rubber tires. Side rails can be raised to two positions or lowered entirely out of the way. The intravenous attachment has sockets on each side of the litter, and a durable hydraulic lift for Trendelenberg position elevates approximately 12 inches. 72" long, 30" wide and 33½" from the floor, the Gendron stretcher is made with sturdy, welded tube construction and conductive aluminum bronze finish. Wheels: 10" diameter, disc type ball bearing. Ball bearing swivel forks. 1⅛" conductive rubber tires. Model 869, same, except of stainless steel at additional cost. Write today for Gendron's complete catalog.

GENDRON ... FOR OVER 85 YEARS THE QUALITY MANUFACTURER OF WHEELED EQUIPMENT FOR THE PATIENT OR THE HANDICAPPED

THE GENDRON WHEEL COMPANY
PERRYSBURG, OHIO

ADLAKE...A-PLUS!

Lashed by 25 m.p.h. winds, flames from the Memphis stadium towered like a gigantic blazing tongue above the roof of the Baptist Memorial hospital . . . licked hungrily at its face and the *Adlake* double-glazed reversible aluminum windows. For more than half an hour temperatures stood at Fahrenheit 1200° plus, the melting point of aluminum. Yet, no *Adlake* windows gave way. Frames retained their square . . . weatherstrips their seal—thanks to *Adlake's* built-in *safety of quality.* "Without those windows, we would have had a bad situation," firefighters agreed. Officials credited Adlake double-glazed windows with having "saved the life of the hospital" not to mention human lives that may well have been spared. Write for 36-page catalog of non-residential aluminum windows and curtain walls.

The Adams & Westlake Company
Elkhart, Indiana

Weatherstrip still intact, this Baptist Memorial hospital window, typical of the *Adlake* reversibles exposed to flame, retained its glass in spite of temperatures which reached 1200° plus for more than thirty minutes. Unretouched photo reveals how glass cracked but did not shatter.

A+ Adlake
custom windows

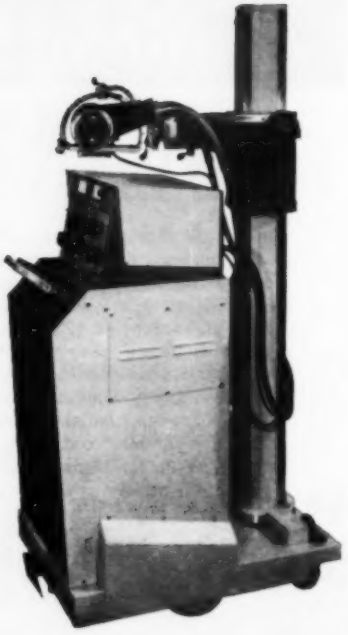
YOU CAN AVOID RETAKES IN MOBILE RADIOGRAPHY

New Westinghouse Newport 200 won't let you make a bad exposure!

Here's why—if exposure *is* attempted on a line where the kv drop is sufficient to reduce penetration to an unacceptable level, the new Westinghouse Expose-Sure circuit *rejects* the technique and lights a "no exposure" light.

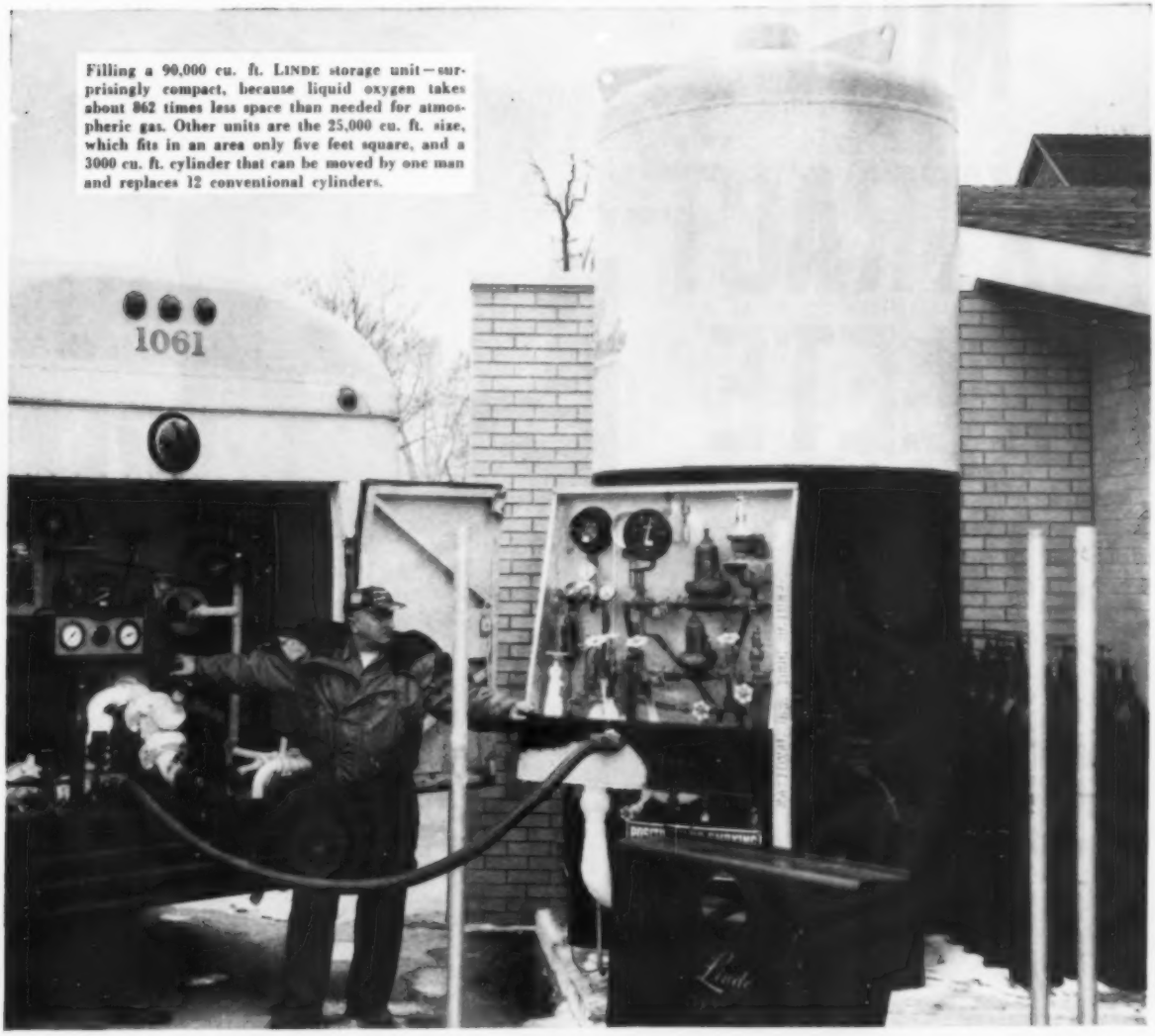
Newport 200 is also current conscious! It automatically compensates via the timer for any change in milliamps—$\frac{1}{20}$ sec through 300 mas. For extra-fast timing, $\frac{1}{60}$ sec is available optionally.

For complete information, please contact your local Westinghouse X-ray salesman, or write Westinghouse Electric Corporation, X-ray Department, Section 380, 2519 Wilkens Avenue, Baltimore, Maryland. J-08380



YOU CAN BE SURE...IF IT'S Westinghouse

WATCH WESTINGHOUSE FOR NEW DEVELOPMENTS IN RADIOLOGICAL EQUIPMENT



Filling a 90,000 cu. ft. LINDE storage unit—surprisingly compact, because liquid oxygen takes about 862 times less space than needed for atmospheric gas. Other units are the 25,000 cu. ft. size, which fits in an area only five feet square, and a 3000 cu. ft. cylinder that can be moved by one man and replaces 12 conventional cylinders.

YOU'VE GOT TO BE SURE ABOUT OXYGEN

With hospital oxygen, you've got to be sure that it's produced to U. S. P. standards . . . that it's properly stored and handled . . .

And you've got to be sure that it's there when you need it.

You don't face problems like these when you have a LINDE liquid oxygen system installed. Any general hospital from 25 beds up can have liquid oxygen. Experienced LINDE representatives are ready to help in selecting and installing the equipment you need. You will find that liquid oxygen takes only a fraction of the storage space required for gas. Highly qualified personnel supervise its production all along the line. And deliveries are regular and dependable, wherever your hospital may be located in the United States.

Take advantage of more than 50 years of LINDE experience in the oxygen business. Call your nearest LINDE representative or distributor. Or write Linde Company, Division of Union Carbide Corporation, 30 East 42nd Street, New York 17, N. Y. *In Canada:* Linde Company, Division of Union Carbide Canada Limited, Toronto.

Linde UNION CARBIDE

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NOW EXTRACT COMPLETE LOADS WITH

Extraulic Extractor's high, equalized working pressure — A.S.M.E. certified for 400 p.s.i. — forces diaphragm bag to conform to shape of load, eliminates pockets where water might collect. A built-in reservoir stores water from pressure chamber for re-use — greatly reduces water consumption, eliminates need for separate water tank.

It's fast, vibration-free
and job-balanced
with big-volume washers!

AMERICAN'S NEW 225-LB. EXTRAULIC!

No load splitting, no leftover work. The new 225-lb. Extraulic Extractor handles *complete pocket loads* from 42" or 60" dia. Washers — and at rates of up to seven loads per hour.

The Extraulic comes up to pressure in just two minutes, then completes extraction cycle in another six minutes. The 1824 perforations, in pressure chamber cover and top ring, permit unusually fast discharge of water from work.

A pressure-type extractor, American's new Extraulic operates without vibration. No special foundation is required, no special wiring is needed. Can be installed easily and economically in minimum space, even on upper floors.

With full-load capacity, the Extraulic is an ideal working mate for all popular size, big-volume washers. Hoist loading and unloading makes operation easy, saves time and labor.

Find out today how *you, too,* can enjoy the benefits of vibrationless, big-volume extraction at the lowest possible cost. Call your nearby American representative, or mail the coupon for complete information.

THE AMERICAN LAUNDRY MACHINERY CO., CINCINNATI 12, OHIO

The American Laundry Machinery Co. ALM-712
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Send complete information on American's new 225-lb. Extraulic Extractor.

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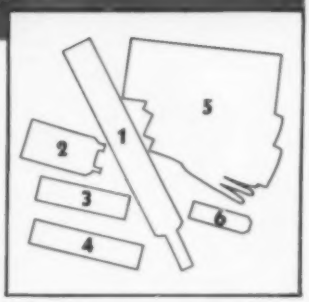
ON EVERY PRO-TEX-MOR STERILIZER BAG

AND IT WORKS EVERY TIME!



1 Catheter Bag
2 "Duet" Syringe Bag 2CC-5CC
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4 Single Syringe Bag 30CC-50CC
5 All Purpose Bag
(Shown with individual wallets for sterilizing gloves)
6 Needle Bag

Proven, effective, accurate and convenient. Indicator Mark changes from pink to brown *only* under proper sterilization. Bags are made of wet strength paper with waterproof seams to resist sterilization temperatures. (Bags also available without Sterilizer Indicator Mark.)

Write for samples and catalog

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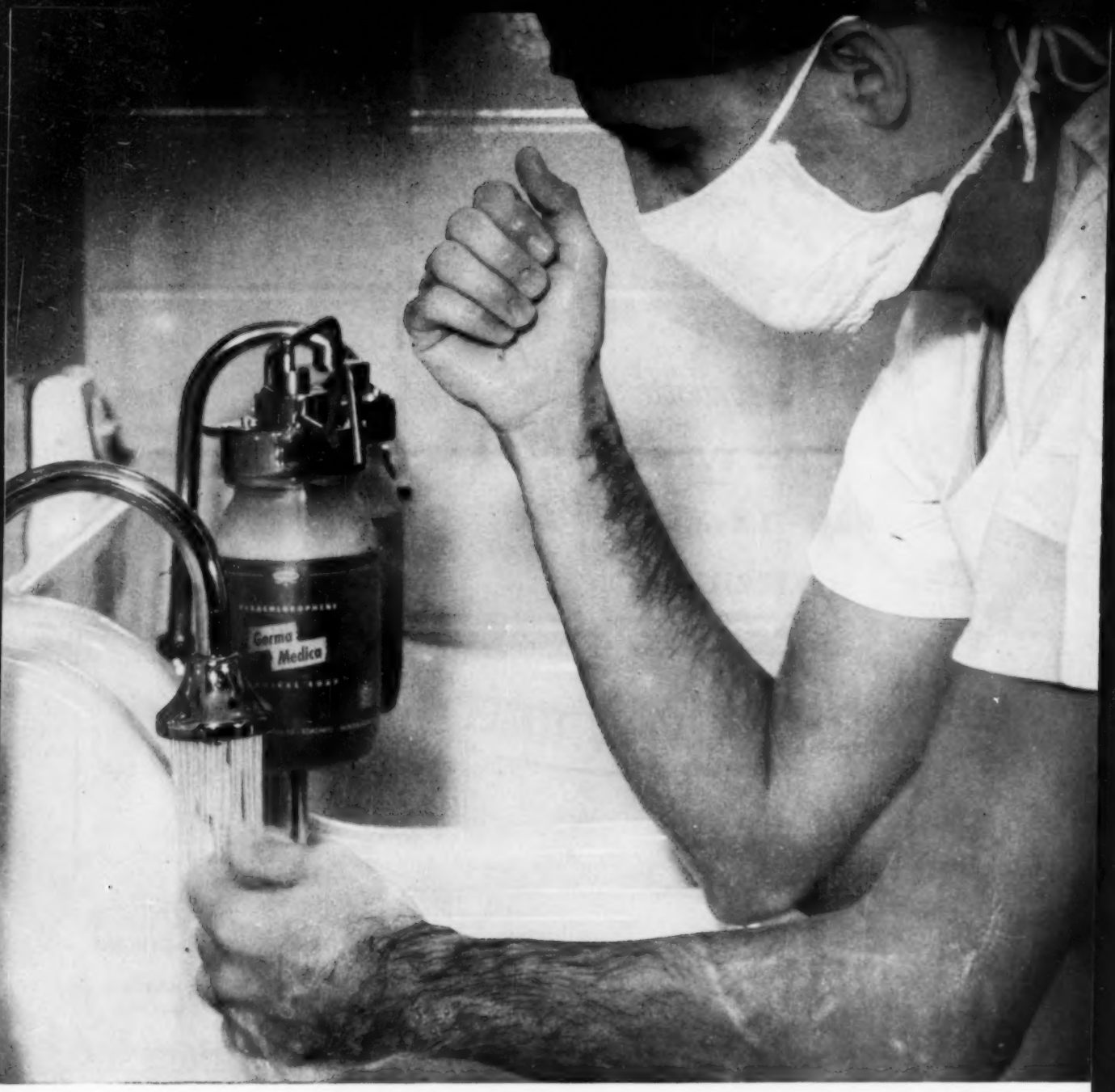

GERMA-MEDICA® LEAVES HANDS SURGICALLY CLEAN

WITH HEXACHLOROPHENE

WITHOUT THAT "DRIED-OUT" FEELING . . .

Germa-Medica Liquid Surgical Soap with Hexachlorophene has had a long history of being the favored surgical soap for the surgeons' prep in many hospitals. It not only cleans hands to a degree approaching sterility, with routine, regular use, but it also helps keep hands smooth and soft. Germa-Medica includes imported olive oil and other oils which increase its emollient effect on the skin.

Germa-Medica with Hexachlorophene is low cost and mild . . . making it an ideal antiseptic soap for use at **all** hospital stations.

A special preservative in Germa-Medica is highly active against all kinds of bacteria, including Gram negative microorganisms. This preservative protects Germa-Medica against contamination that can result in handling, from the shipping containers to the dispenser jars, with a wide margin of safety. See our representative, the Man Behind the Huntington Drum, for full details and send for the Germa-Medica Liquid Surgical Soap with Hexachlorophene Research Bulletin to get annotated test results.

Where research leads to better products . . . **HUNTINGTON**

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Architects: Neville, Sharp and Simon, Kansas City

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Bright and cheerful, comfortable and efficient, Vina-Lux vinyl asbestos tile keeps pace with modern trends in hospital design.

Vina-Lux beauty is fresh, light-reflectant, permanent. Its resilience reduces noise, increases safety and adds comfort underfoot. Its versatile beauty fits any decorative scheme.

Vina-Lux is made with a tighter-textured surface to repel wear and tear ...to simplify cleaning...to cut maintenance costs to the minimum.

Vina-Lux – the perfect answer to every modern hospital flooring problem! Write for samples and color catalogue, "Floors for Modern Hospitals."

AZROCK FLOOR PRODUCTS DIVISION
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UVALDE ROCK ASPHALT CO. • 514 FROST BANK BLDG. • SAN ANTONIO, TEXAS

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SMALL HOSPITAL QUESTIONS

What Courses To Take

Question: I am seriously considering entering the field of hospital administration and would appreciate any information as to a curriculum to follow. I am presently a freshman at the University of Illinois, enrolled in psychology.

I discussed my intentions with one of the directors of the local hospitals here, and he suggested that I enroll in the College of Commerce and major in accountancy.

I will sincerely appreciate any help you could offer. — N.M.N., Ill.

ANSWER: Although there is no specific undergraduate program that leads to an advanced degree in hospital administration, it is generally acknowledged that the preferred college curriculum should include a broad liberal arts background with at least introductory courses in biological sciences, accounting and business administration.

The American College of Hospital Administrators will send upon request a brochure, "Hospital Administration as a Career," which describes the field in general and lists those universities currently offering graduate courses in hospital administration. Approximately half of these programs are in schools of medicine or public health and the remainder are in schools of business.

Here's Help on Narcotics

Question: This 120 bed hospital is revising its pharmacy procedures. Where can we obtain information about the proper handling of narcotics in hospitals? — J.A.D., Mo.

ANSWER: A copy of Regulations No. 5, which contains the joint narcotic regulations made by the commissioner of narcotics and the commissioner of internal revenue should be available in every hospital. This publication is available from the superintendent of documents, U.S. Government Printing Office, Washington 25, D.C. It is designated as I.R.S. Publication No. 428 (6-59).

Two reprints are available from the American Society of Hospital Pharmacists. One, Suggested Regulations for the Handling of Narcotics in Hospitals, has been recently mailed to every hospital administrator in the country. Additional reprints are available at a cost of 25 cents each. Another reprint, The Law of Hospital Pharmacy, is available at 50 cents and will be helpful on a variety of legal problems relating to hospital pharmacy practice, including narcotic control.

Rule on Record Librarians

Question: Does the Joint Commission on Accreditation require that a hospital hire a full-time medical record librarian? — N.K., Tenn.

ANSWER: No.

Discussing this subject at the Tri-State Hospital Assembly this year, Martha Johnson, R.N., assistant to the director of the Commission, made the following points:

"A medical record must be kept on every patient admitted for care in the hospital and it is certainly a great help to have a professionally qualified person in charge of the department. Where this is not possible or where the volume of work perhaps does not warrant a full-time trained librarian, a consultant or part-time person may fill the need. She would set up the files, establish procedures, and visit the hospital at regular intervals to supervise and instruct personnel.

"So far as indexing medical records is concerned, the Commission requires that records be indexed according to disease, operation and physician. It should be emphasized that this is a simple index only, and cross-indexing and coding are not required.

"The physician is responsible for the content of the medical record and only a physician can write or dictate a history and physical examination. The quality of the record is not based on length but on whether it contains sufficient information to justify the diagnosis and warrant the treatment and end result. In small hospitals where the physician must write his own records, he does not have time to write long, so-called 'teaching hospital' records. This the commission does not require. It does require that the record contain enough information so that if it were necessary for another physician to assume the care of the patient, he could do so intelligently, without detriment to the patient and without loss of time and continuity in treatment. The record should also be meaningful in the event of a subsequent admission to the hospital."

ANY QUESTIONS?

The Modern Hospital will be glad to try to answer them.

If you have a problem or if you're just curious about a procedure or a statistic, please feel free to write this department, care of The Modern Hospital, 919 North Michigan Ave., Chicago 11.

Are O. R. Doors Essential?

Question: What is the current thinking with respect to doors on operating rooms in hospital surgeries? There seems to be divided opinion on this subject among surgeons. Some feel that doors to individual operating rooms serve no useful purpose. They say that any advantages that the doors have are outweighed by nuisance and hazard. For example, there is greater stirring of air throughout the entire surgery area from opening and closing the doors, especially those of the swing type.

Others think that doors provide for better control of possible cross-infection and, of course, provide more privacy and quietness.

ANSWER: Most authorities agree that, in spite of the problems of swinging doors, with resultant air movement, the barriers to cross-infection are improved when such doors are present.

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HEALTH CARE ISSUE NEARS CLIMAX

With Congress racing toward adjournment, the bitterly contested issue of health care for the aged is swirling around in a political and parliamentary whirlpool.

At this writing, the situation is complex and confusing, but these are the facts:

1. The House of Representatives has passed a social security bill that contains the most modest plan of all those proposed to help the aged pay their hospital and doctor bills. It would extend help, from U.S.-state funds, to people over 65 years of age who can demonstrate they can't afford to pay for hospitals, doctors and drugs. It would merely expand the long-standing public assistance program under which the U.S. contributes money to states to help pay medical care bills for the needy aged, dependent children, the disabled, and the blind.

Under the present program, there has to be a show of need—evidence that the beneficiaries do not have sufficient money to pay for food, lodging and clothing as well as medical care. They are "welfare cases." The new plan would set up a new classification of "medically indigent," that is, people who can meet ordinary bills but can't pay for extended illnesses. States would decide how to make these determinations, but regulations would have to be approved by the Department of Health, Education and Welfare.

This plan would cost the U.S. an estimated $165 million a year – more than is now spent on medical bills of welfare cases; it would cost the states a little less. This would be in addition to the $200 million or so the U.S. now pays toward medical care bills of welfare patients.

2. Now past the House, the issue moves on to the Senate. There the sponsors of Forand type legislation – health insurance under social security – will meet head on the backers of the "paupers bill." Behind-the-scenes forces will be the same as they have been for more than three years – American Hospital Association, American Medical Association, and a number of other groups that are determinedly opposed to anything like the Forand bill, as well as labor and other liberal elements attempting to put over hospitalization under social security.

The American Medical Association has come out in favor of the House plan – the "medically indigent" approach – but the American Hospital Association has not declared itself. Liberals generally don't want the House bill – they want to help *all* old people, not only those who are willing and able to demonstrate they are indigent. For example, Rep. Aime J. Forand (D.-R.I.) himself voted for the House idea "just to keep the issue alive," but denounced it as a "paupers bill" and inadequate.

3. In the Senate, support is rallying to a "Forand" bill introduced by Sen. Pat McNamara (D.-Mich.), after his subcommittee conducted a long series of hearings in Washington and across the country on problems of the aged. A solid block of 23 other senators has joined Senator McNamara in sponsoring his bill. It includes almost all of the Senate's liberals, and a few generally considered middle-of-the-road. They also have the support of a number of senators who haven't joined in with Senator McNamara only because they have their own bills that differ from his in details.

The McNamara bill, carefully worked out after study of the Forand bill, would take in retired women at 62 and retired men at 65 who are under social security, and *all* persons 72 or older. Senator McNamara's staff decided that doctors' bills (covered in the Forand bill) are not the major concern of the elderly, but that outpatient services (not covered by Forand) are.

The McNamara plan provides for, in addition to hospital benefits, diagnostic, nursing home and home health services. It would also pay part of the drug bills, and set aside funds for research on the medical problems of the elderly.

4. Senator McNamara and his supporters hope to amend the bill on the Senate floor. They will attempt to substitute his omnibus plan for the restricted, "indigent only," House plan. While House acceptance of the Forand plan is expected, if it passes the Senate, the time factor is all important. It likely will be so late in the session that any extended debate might endanger the entire social security bill. Few senators would be willing to risk this disaster. Also, even the most liberal members realize that even a weak bill would be better than doing nothing for the old people, particularly in an election year.

5. If the McNamara program does somehow become a part of the bill, and reaches the White House, a presidential veto of the whole social security bill is not out of the question. Mr. Eisenhower has said repeatedly that he opposes the social security approach or "compulsion" in any form. Here again timing is of the utmost importance. The conservatives who have embraced the moderate House bill are hopeful that enough time will slip by so Congress will have to accept the bill as it now stands – without the Forand principle. The President's advisers hope that if the Forand idea is inserted, the bill will reach the White House soon enough so Mr. Eisenhower can veto it and toss the issue back to Congress with the warning: "If you don't want to be blamed for loss of the social security bill, take out the Forand plan."

6. H.E.W. Secretary Flemming—who favors the social security approach but couldn't sell Republican congressional leaders on it – is convinced that the Administration's plan will win out in the end. He believes that congressional insistence on a broad plan to help the aged, and Mr. Eisenhower's determination not to permit use of the social security system, will carry the day for his plan. This is a complicated U.S.-state program of insurance for *all* the aged, financed by U.S. and state money.

7. If the conservatives have their way – thanks to the

time element and careful maneuvering – it will be a temporary victory. Sen. Lyndon B. Johnson (D.-Tex.) is the only presidential aspirant among the Democrats who has not endorsed the Forand idea, so it is assured a place in the party's platform. In self-defense, the Republicans will also have to offer quite a bit to the older voters and their families. Thus, if the "indigents only" plan is the best that Congress produces, the issue will be fought out all over again next year.

NO CUTBACK IN HILL-BURTON FUNDS

The Hill-Burton hospital construction program is virtually certain to have for next year at least as much money as it is spending this year – $186.2 million.

As it has in the past, the Senate appropriations subcommittee voted H-B a healthy increase over the figure proposed by the House, which itself had boosted the recommendations of the President and the budget bureau. The full committee approved the subcommittee's report without change. The Administration cut the total down from this year's $186.2 million to $126.2 million, following which the House subcommittee increased it to $150 million, a figure approved by the full committee and the House.

When its turn came, Sen. Lister Hill's (D.-Ala.) subcommittee went all the distance the law allows, or a total of $211.2 million. It is broken up into $150 million for the "old program," $60 million for the "new program" (nursing homes, diagnostic-treatment centers, rehabilitation facilities, and chronic disease hospitals) and the usual $1.2 million for research in hospital use.

The American Hospital Association and other friends of the hospitals failed in only one respect–they wanted $5 million for research instead of the $1.2 million voted by both committees and the House. Assuming there is no change on the Senate floor, this will be the final figure, as it won't be submitted to the Senate-House conference.

In justification for the $60 million boost, the Senate committee's report carries only one brief paragraph: "Plans submitted by state agencies administering the Hill-Burton program show the need for 1,102,432 additional hospital and nursing home beds. The total amount here recommended, plus expected construction outside the program, will produce only 54,222 beds, or almost 14,000 fewer beds than are required annually for population increases and replacement of obsolete beds."

The committee also added $131,800 to the House figure of $1.6 million for administration costs, explaining that the extra money would be needed to handle the expanded program proposed by the committee.

If the pattern of other years holds true in the Senate, the committee's recommendations will be debated, but approved with little change. Whatever scaling down is done will come in the conference committee where, in the past, the high Senate appropriations have generally prevailed over the House figures.

Generous as was the Senate committee's increase for the Hill-Burton program, it fell far short of the two-thirds increase proposed over House figures for the National Institutes of Health.

N.I.H. this year is spending $400 million, and the Eisenhower Administration proposed exactly that amount for the fiscal year starting July 1, 1960. The House settled on $455 million, but the Senate committee whooped this up to $664 million.

The $664 million is almost exactly the figure recommended by a special committee of medical consultants that had made a study of medical research needs at the request of the subcommittee. The committee's report has high praise for the consultants, declaring:

"The committee wishes to take this opportunity to pay tribute to the chairman, members and staff of the committee of consultants on medical research. Their's was a dedicated, imaginative and inspired performance. They gave unstintingly of themselves and their time . . . . Their report will serve as a bench mark for many years to come, and the entire nation is indebted to them. The report . . . urges a leading and positive role for the federal government in the support of medical research and confirms the essentiality of accenting and sustaining program trends which were already beginning to be in evidence. . . ."

In contrast, the Senate committee, in this election year, took a vicious swing at the Eisenhower Administration:

"It is surprising to the committee that in recent years – when the advances in medical research have been so gratifying, the needs so challenging, and the opportunities so evident – the appropriation requests (Administration's) on behalf of the National Institutes of Health have reflected a reluctance to recognize needs and to capitalize on opportunities. Indeed, the appropriation requests have given every appearance of being handled as if by some arbitrary formula.

"As a result, Congress has been required to assume leadership in this field. It has done so willingly, guided by broad expressions of view of what the people need, want and expect of their government in this matter.

"Yet the inescapable fact is that between 1956 and 1960 – a period of time in which the total appropriations to the National Institutes of Health have increased from $161.7 million to $400 million – in no year has the budget request included any appreciable increase over funds appropriated the preceding year."

H.E.W. ORDERS DRUG SAFETY STUDY

Secretary of Health, Education and Welfare Arthur Flemming recently announced that an investigation will be undertaken to determine the adequacy of Food and Drug Administration procedures for putting new drugs on the market. The investigation will be conducted by an independent group of scientific experts. Secretary Flemming also said F.D.A. reviews of promotional literature for prescription drugs would be tightened; he asked for legislation to provide F.D.A. with authority to conduct factory inspections and require reports from manufacturers on adverse reactions to drugs.

NOTES:

Hospitals shared in the distribution of $91.1 million (U.S. purchase price) in federal surplus material in the first quarter of the year. Included were hospital, medical and dental school furniture and equipment, and many vehicles. Interested hospitals should contact state surplus property officers for details of future distributions.

The Modern Hospital
JULY 1960

LOOKING AROUND

No Problems?

REPORTERS attending a "problem-solving clinic" at the Tennessee Hospital Association convention last month may have come away thinking Tennessee hospitals were in a class by themselves. According to an eyewitness report, this is what happened:

2:02 p.m.—Chairman James Ferguson called meeting to order. Told two real funny stories.

2:05 p.m.—Turned meeting over to Moderator Everett Jones, who told one fairly funny story and then asked each panel member in turn if he had any questions or comments. Each one said No.

2:08 p.m.—Moderator asked the audience for questions.

2:08¼ p.m.—Moderator said: "Since there are no questions this session is closed." The panel was then given a rising vote of thanks.

Actually, Tennessee hospitals are not without problems, as an observer might have concluded, nor do Tennessee hospital people think they know all the answers. The problem clinic was cut short by prearrangement to provide time for a business session. Panel members heard all the questions, and struggled to find helpful answers, in the usual corridor conferences.

Nonsense

AT ONE of this year's state hospital conventions, a noted hospital authority declared that government control of hospitals in the U.S. is imminent, because hospitals here are confronted with "the same signs and symptoms that preceded nationalization of hospitals in England in 1938."

The British National Health Service was inaugurated in 1948, not 1938, but this ten-year error comes a lot closer to the truth than anything else in this statement does. Excluding psychiatric facilities, which are under a separate law in Great Britain and are largely the responsibility of the state governments here, the majority of beds in U.S. hospitals are still in private, voluntary institutions. In Great Britain the reverse was true for many years before the National Health Service Act; the majority of general hospital beds were under municipal or "local authority" auspices, many operated as branches of local poorhouses. These facilities were an unbearable strain on local resources and local authorities, who were vastly relieved when nationalization lifted the burden. This situation has no counterpart in the United States today.

Voluntary hospitals in the United States (whose trustees were castigated as "do-nothing, know-nothing, don't-care" by this hospital authority in his incredible convention speech) have never been stronger financially than they are today. It is of course true that some large voluntary hospitals with heavy teaching and charitable loads, and some community hospitals which are paid less than cost by local governments for care of indigent patients, have faced mounting deficits in recent years. By and large, however, hospital care in our voluntary institutions is on a sound, pay-as-you-go basis; in the last full year for which figures are available, expenses in voluntary hospitals totaled $29.24 per patient day, while total income was $30.19, allowing a neat 95 cents to help provide plant replacement and other long-term financial needs.

In contrast, the financial plight of Britain's voluntary hospitals had been serious after World War I, worsened during the general strike of 1926 and the depression of the Thirties, and became desperate during World War II, by which time the government was already paying for a major share of the nation's hospital bill under wartime emergency measures. With the exception of a handful of endowed teaching hospitals, the voluntary hospital system in Great Britain was insolvent when the government took over in 1948. There is not even the remotest resemblance to this situation in the U.S. hospital economy today. Blue Cross, with all its current difficulties, provides a solid billion dollars a year to support the voluntary hospital structure; insurance guarantees another billion or more. Britain's voluntary "contributory schemes," on the other hand, furnished only a feeble trickle of hospital income before the war and vanished afterward.

Finally, the political climate that made nationalization of British hospitals inevitable is completely lacking in the United States, much as some opponents of the Forand Bill and other government aid measures that have been proposed here would like to find a parallel. Actually, the For-

and Bill, which never had a chance of passage, was a much less drastic measure than the compulsory health insurance for workers that was introduced in Great Britain by Lloyd George's government in 1912 and remained in effect until the National Health Service Act was initiated. A substantial number of British doctors and their patients have thus been accustomed to "panel medicine" under government auspices for nearly 50 years, while most American doctors still recoil in horror from the panel medicine that is managed by private enterprise in this country and offers a substantial measure of free choice to participating physicians and beneficiaries. For whatever reasons, the British Medical Association went along with the Labor government in the nationalization program for medicine and hospitals there; considering the American Medical Association's position, it staggers the imagination to picture what would happen here if anyone seriously proposed nationalization of medical and hospital care, which no one has ever done. The British Hospitals Association offered no alternative to nationalization, and most of its members welcomed and supported the scheme when it was introduced. With its vigorous programs supporting hospital efficiency and independence, the American Hospital Association is representative of a totally different spirit emerging from a totally different set of circumstances. To suggest that the spirit and the circumstances are similar and that a government takeover of American hospitals is imminent is irresponsible nonsense.

Supervisors

THE shortage of professional nurses for hospital duty has been with us for 15 years now, and everybody understands it is permanent and can never be solved, but only relieved by employment of auxiliary personnel on nursing floors. Thus the safety and comfort of patients depend heavily on the quality of supervision in nursing departments; recognizing this, hospital and nursing executives in recent years have been studying supervisory training methods and introducing training programs to prepare promising employes for supervisory responsibilities. Of course, supervision is important in all departments, and supervisory training is not limited to nurses, but the need has generally been felt most acutely on nursing floors.

Supervisory training methods have been borrowed and adapted from industry or other hospitals or improvised to meet individual hospital needs, in many cases successfully, and supervisory training has become a definitive responsibility for the hospital administrator, like preparing the budget or firing the cook. But the most carefully planned and smoothly executed training program is no better than the people who are being trained. Role-playing and visual aids don't make supervisors; God makes them, and training simply makes it possible for them to function effectively. Too often, management has assumed that any good nurse can become a good supervisor. Unhappily, this is not the case; job knowledge and technical skill at the tasks to be supervised are important qualifications for a supervisor, but these are initial rather than final considerations in the identification of supervisory talent. A gentle hand with patients may be a hard fist with subordinates.

The selection of qualified personnel for supervisory training has been studied extensively in industry, and, while it is unlikely that a head nurse and a boss steamfitter would have many characteristics in common, some of industry's criteria may work just as well on the ward as they do in the yard. In industry, for example, management is convinced that the physically active, energetic employe is a better supervisory bet than one who moves seldom and slowly. Of course, a slow foot doesn't necessarily indicate a slow wit, and the quick-stepping nurse will not always make a better supervisor than her lead-footed sister, but the odds favor it.

Employes who rattle under pressure or smart under criticism are poor supervisory risks, the book says. Supervisors must remain calm in emergencies and accept criticism objectively. These qualities cannot be painted on in a training program; if possible they should be observably present in the employe who is selected for training. The nurse who always resists when a new procedure is introduced or a change in schedules is necessary is questionable supervisory material, because she may lack necessary flexibility; the ideal supervisor's character includes built-in shock absorbers that permit quick adjustment to new situations and demands. Industries commonly spend thousands of dollars for psychological tests to find out whether or not employes have these qualifications. In the hospital, changes and emergencies are common enough for such determinations to be made by inspection; any floor supervisor knows which nurses flap and which ones don't.

Finally, good supervisors give easily understandable instructions and enjoy the respect and trust, if not always the affection, of their subordinates. Thus the employe who is articulate has an edge over the one who is tongue-tied, and the hard worker should be chosen ahead of the backslapper. The underpinnings of trust may be harder to discern; honesty and reliability are not obtrusively visible at all times. But industry has a rule that hospitals should certainly follow: Never promote a known trimmer.

Some nursing educators have suggested that preparation for nursing assignments may be divided by levels of responsibility — short courses for aides and attendants, a year of training for practical nurses, three-year schools for general duty and degree courses for head nurses and supervisors. The proposition has an attractive logic, but experience in industry warns against raising educational barriers to advancement from the ranks. "What education must the supervisor really have in order to be able to do the job?" asked a recent article in *Dun's Review and Modern Industry*. "Each unnecessary qualification reduces the number of possible candidates and thus gives management less freedom of choice. The trick is to fill the job that is actually open, not some imaginary position somewhere near the presidency."

Hospitals, at least, don't have to worry about reducing the number of candidates; in today's urgent situation, unfortunately, every able-bodied nurse has to be considered a candidate. In too many instances hospital and nursing administrators are permitted only one standard: If she can read and write, give her the job!

The nursing shortage can be solved, but only when nursing leaders learn to adjust the educational system to the changing needs of nursing service

Are Nurses Holding Back Nursing Education?

Maj. Edith Aynes, A.N.C. (Ret.)

WE AS nurses like to think of ourselves as leaders on the world health scene. We consider ourselves vital to public health, to industry, to schools, to hospitals, to private patients, to mental institutions, to doctors, to the armed forces, to research, to civilian defense, to all governmental agencies such as the Children's Bureau, the Veterans Administration, and the Indian Service. We *know* we are vital to the teaching profession in our own field – both as formal educators and as supervisors in wards, clinics and operating rooms, as well as deans of professional schools, practical nurse schools, and administrators of nursing services, and even, sometimes, as hospital administrators.

But we as nurses also like to think of ourselves as vital to the patient – at the bedside. We believe we should be his nurse, his liaison with the doctor, the teacher of his family, his bridge to the community.

We seem to believe we can be all these things to all people, to all agencies, to all organizations, all communities, and all nations. We don't know how we have been able to do it all, but we congratulate ourselves that we have done a very fine job.

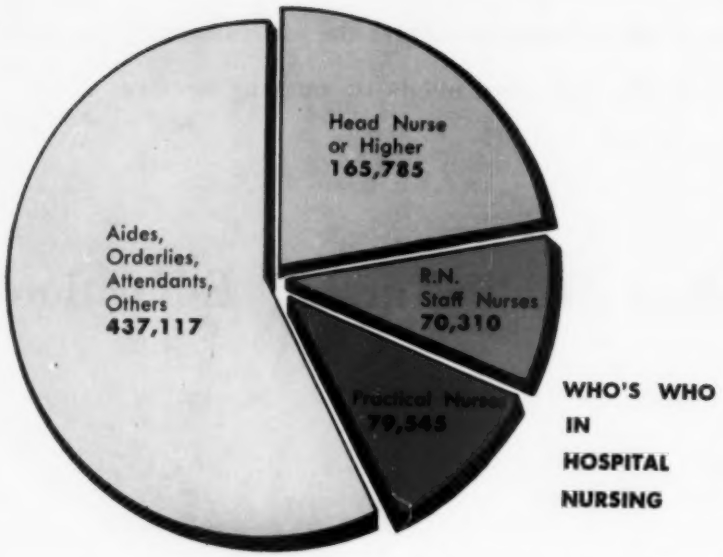
Realism has never been one of our strong points.

Beginning with World War II, we began to talk about the "shortage" of nurses. We as a nation were so short of nurses that we had to call upon the untrained women of the country to save the wounded. We have never been anything but short since. We have used the word so long and it has become so familiar that we have contempt for it. Its meaning in relation to nurses has lost its impact.

We have heard that the world is undergoing a population explosion – and we understand that it is due to an increased birth rate with a corresponding reduction in the death rate. We even know that the reduction in the death rate poses a new problem for us in the nursing profession: the pressing needs in the field of geriatrics. Twenty-five thousand nursing homes ought to be staffed with capable persons.

We are aware that the world popu-

Miss Aynes is coordinator of information for the department of professional education, the National Foundation, New York.



Registered nurses constitute less than a third of the total of 752,757 nursing personnel working in hospitals, according to statistics compiled by A. H. A.

lation is increasing at the rate of 47 million people every year and that more than 3 million of those belong to the United States. We attend world health conferences and devote hours of attention to the problems of nursing in other countries.

Complacent About Patients

But for some reason we do not seem to understand what has happened in our hospitals here at home. We are as complacent about the fate of patients as the best of complacent Americans.

Our progress in nursing education for the last 15 years has in no way kept pace with the demands of these phenomenal changes — nor with the changes in responsibilities for professional nurses that have come about with the increase in medical knowledge and the gradual withdrawal of the doctor from the patient's immediate environment. The shortage of physicians has forced a rise in the status of the professional nurse, and because of it we have had to better ourselves educationally. Because of increased recognition in a wider variety of jobs outside the hospital, we have moved up on the social scale, even up on the financial scale wherever possible.

But as nurses we have failed in our responsibility to society. We have moved up — and out — and in so doing we have left the side of the patient and have consistently refused to provide a fill-in to replace us. We have put our tongues in our collective cheeks and have said magnanimously that the practical nurse is the answer to the problem of patient care; that she is the teammate of the professional nurse.

Here our inconsistency begins to show.

We insist that a nurse — to be at the patient's side — should be a professional nurse, a health teacher, a psychologist, a chemistry major, a qualified social worker. The nurse at the patient's side must have at *least* three years of training in an approved school of nursing or she must have two years in a college with another two years of practical training before she can function adequately — and safely — in nursing patients. Our schools are training professional nurses to give direct care to patients, knowing full well that the minute the nurse graduates she will have — by sheer necessity brought about by the shortage — to assume the responsibilities of a head nurse at least.

Without a care in the world, then, we say that the practical nurse, who has free access to the patient, can give the greater part of the nursing care that is required and to do this she needs only two years of high school and one year of basic preparation — to accomplish all the complicated procedures that it takes a professional student (ostensibly a brighter student since she must be in the upper half or third of the graduating class) three times as long to learn.

Confused About Personnel

Then, without blinking an eyelash, we calmly announce that the practical nurse must work under the supervision of the professional nurse, who, having come from a course designed to teach direct patient care, has never learned about personnel management, hospital administration, or the technics of teaching and supervision — a professional nurse who is, in fact, confused as to what is proper for her in her relationship with practical nurses and all the other personnel she finds on the wards.

The latest hospital statistics from the American Hospital Association list 236,095 graduate nurses employed full time in 6282 hospitals throughout the United States. Of this number 165,785 are listed as "administrators, instructors, supervisors, head nurses, anesthetists, operating room, or private duty nurses." This would leave 70,310 graduate nurses for general duty — presumably at the bedside of patients, three shifts, for 40 hours of duty a week.

So who is taking care of the patients? You are right: 516,662 nurse's aides, orderlies and others, and included in this figure are 79,545 practical nurses.

If this is true today, what will the situation be tomorrow when a need for twice the facilities has been predicted?

TIME BETWEEN ECONOMICS AND MUTTERING ABOUT N.L.N.

Eighty-three per cent of our schools today are three-year hospital schools, and whatever else they are preparing nurses to accomplish, it is not supervision, nursing administration, or teaching. Some of these schools are excellent, some are average, and some are less than average. Some of these schools produce a graduate in three years who is comparable to a practical nurse with one year's training at a good school. Some of the better three-year schools produce a professional nurse who is better than some of the collegiate schools can produce in four or five years.

So what do we, as a professional group, do? We fight among ourselves about the structure of our professional organizations.

The American Nurses' Association divides its time between the economic security program and muttering about the National League for Nursing. We as nurses are striving so hard for status control within the ranks of nursing itself that we have no time to worry about the over-all requirements of the nation for nursing service.

Little wonder that the American Hospital Association and the American Medical Association often ignore professional nursing organizations when they sit down to consider solutions to patient care problems. As long as nurses cannot solve their own personnel problems, there is little chance of their contributing much to the over-all solution of the nation's health problems.

WHAT ARE WE EDUCATING NURSES FOR?

Hospital Nursing*	Other Assignments**
Director, Nursing Service	Public Health
Supervisor, Clinical Service	Supervisor
Head Nurse, Clinical Service	Staff
Medicine—Surgery	Visiting Nurses
Chest	Industrial
Neurology	School Health
Tuberculosis	Armed Forces
Orthopedics	Other Gov't Agencies
Urology	Children's Bureau
Plastic	Indian Service
Obstetrics	Veterans Administration
Newborn	Independent Clinics (Group Practice)
Pediatrics	Organizational and Health Agencies
Geriatrics	Journalists
Psychiatry	Editors
Physiatry	Writers
Outpatient	Research
Anesthesia	Educators
Central Service	Graduate Schools
Operating Room	Collegiate Programs
Supervision	Baccalaureate
Staff	Associate Degrees
General Duty	Diploma Programs
Trained Nurse (R.N.)	Vocational Practical Nurse Schools
Practical Nurse (P.N.)	Nurse's Aide Courses
Nurse's Aide	Home Nursing Teachers
Orderly—Attendant	Midwives

**With the exception of those nurses listed under "General Duty" every category requires some management skills: handling people, accounting, budgeting time and supplies, morale, safety, planning and organization. Basic education above the general duty level should be a baccalaureate degree which has included BOTH nursing and management in the curriculum.*

***Our 1100 schools of nursing must produce enough nurses to meet the expanding requirements of these fields. For most of these jobs, the three-year hospital school does not provide a sufficiently broad base from which to operate.*

The time is overripe for us, as professional nurses, to take a long look at our responsibility to society. We should divide our occupation into *service* and *management*. We should expect our educators, our administrators, our supervisors, our clinical specialists to take the role of *management* through the National League for Nursing.

The American Nurses' Association has already assumed the role of collective bargainer, but the association should speak not only for general duty nurses but for the practical nurses, the nurse's aides, the orderlies, and anybody else who figures in the nursing care of patients.

If there is doubt in anyone's mind about this, consider the situation in New York hospitals during the strike there last year.

The American Nurses' Association, giving guidance to its nurse members as to how to behave during the strike, told them they had legal and ethical obligations to patients and that they should "avoid participation in activities designed to influence the outcome of the dispute."

The nurses were told, in addition, that they should not accept duties normally carried out by non-nursing personnel unless a "clear and present danger to patients exists."

In reporting the strike the magazine, *R.N.*, asked:

"Is it a clear and present danger to the patient if he has nothing to eat? If so, isn't the nurse obliged to help prepare and serve his food if there's no one else to do it?

"Is it a clear and present danger to the patient to lie in a soiled bed? If so, isn't the nurse obliged to change the linen if there's no one else available for this work?"

It is not clear to me how any person attending to the physical needs of patients can be called "non-nursing" personnel. And certainly, concern for a delineation of duties of what *is* and what is *not* nursing does not jibe with what I have always

been taught about a professional nurse taking responsibility for the nursing care of patients.

Concern for a 40 hour work week is to me inconsistent with professional status. I believe staff nurses, practical nurses, nurse's aides and orderlies — anybody who figures in the patients' *physical* welfare — ought to be on the same no-strike contract to which registered nurses on general duty bind themselves. A head nurse comes under the heading of *management,* and she has responsibilities both to the hospital administrator and to the medical staff. I have yet to see a head nurse who was worth her salt walk off a busy ward at the end of an eight-hour day — or even a 40 hour week — if her work was not done.

There is no question that hospital employes should have decent working conditions and decent pay. Nor does anyone dispute the fact that organized labor has made many improvements for the working man in the general business world that otherwise never would have been accomplished.

Army Nurse Corps

	1939	1959*
Colonels	0	3
Lt. Colonels	0	112
Majors	1	1068
Captains	7	1362
1st Lts.	151	506
2d Lts.	480	303
Total Army	639	3354
Total Monthly Pay (base rates)	$61,400	$1,124,902

*Includes regular army reserve corps now on active duty

An increasing number of nurses are being attracted to the Army Nurse Corps, which has increased fivefold during the last 20 years.

But strikes against management that indirectly pressure the public are one thing: The general public can fight back. Strikes against hospital managements pressure the "patient public": a public that is in no condition to fight. Such strikes take an unfair advantage — like hitting a man when he is down. Our juvenile delinquents and gangsters do not hesitate to take this kind of advantage, but it is not generally approved behavior for decent Americans. For hospitals there has to be some other way.

Nurses are underpaid in many places for the work they do, but so long as nursing itself does not clearly draw a line between its management and its service personnel, there can be no clear-cut pay scale that will permit the patient-side nurse to remain with the patient and the nurse who takes management responsibilities, for which she has made extra preparation, to be paid accordingly.

The sooner we establish a clear picture of what we expect from the professional nurse who, in theory, takes her place beside the professionals of medicine, the sooner doctors and hospital administrators will seek to deal with our clearly established, and *competent,* leaders.

Our educational system for training persons for the different levels in the occupation of nursing needs a complete overhaul. Nurse's aides and orderlies and technicians of the army variety ought to have the basic training that practical and professional nurses are supposed to receive. Practical nurses to care for the chronically ill and the aged may or may not do well with the one year of training they are currently receiving. Their performance depends in large part on their native ability and the quality of supervision they receive from the person to whom they report. In many instances their supervision is next to nothing today.

Even at this level of operation it is questionable whether two years of high school are sufficient for the responsibilities being thrust upon these workers. Graduate "patient-side" nurses with a high school diploma could be given enough theory and practice in *two years* in hospital schools to prove reasonably safe, provided they have access to professional nurse leadership that is *qualified* to really supervise their work and give them information and practical help when they need it. Doctors are rarely around enough to provide this supervision any more.

Basic professional education for the future should require at least the baccalaureate degree in accredited schools whose avowed purpose is to educate for expertness in nursing. From this level, the supervisor, the anesthetist, the clinical expert, the school nurse, the industrial nurse, the educator, the public health nurse, the administrative nurse *et al* should specialize with advanced study.

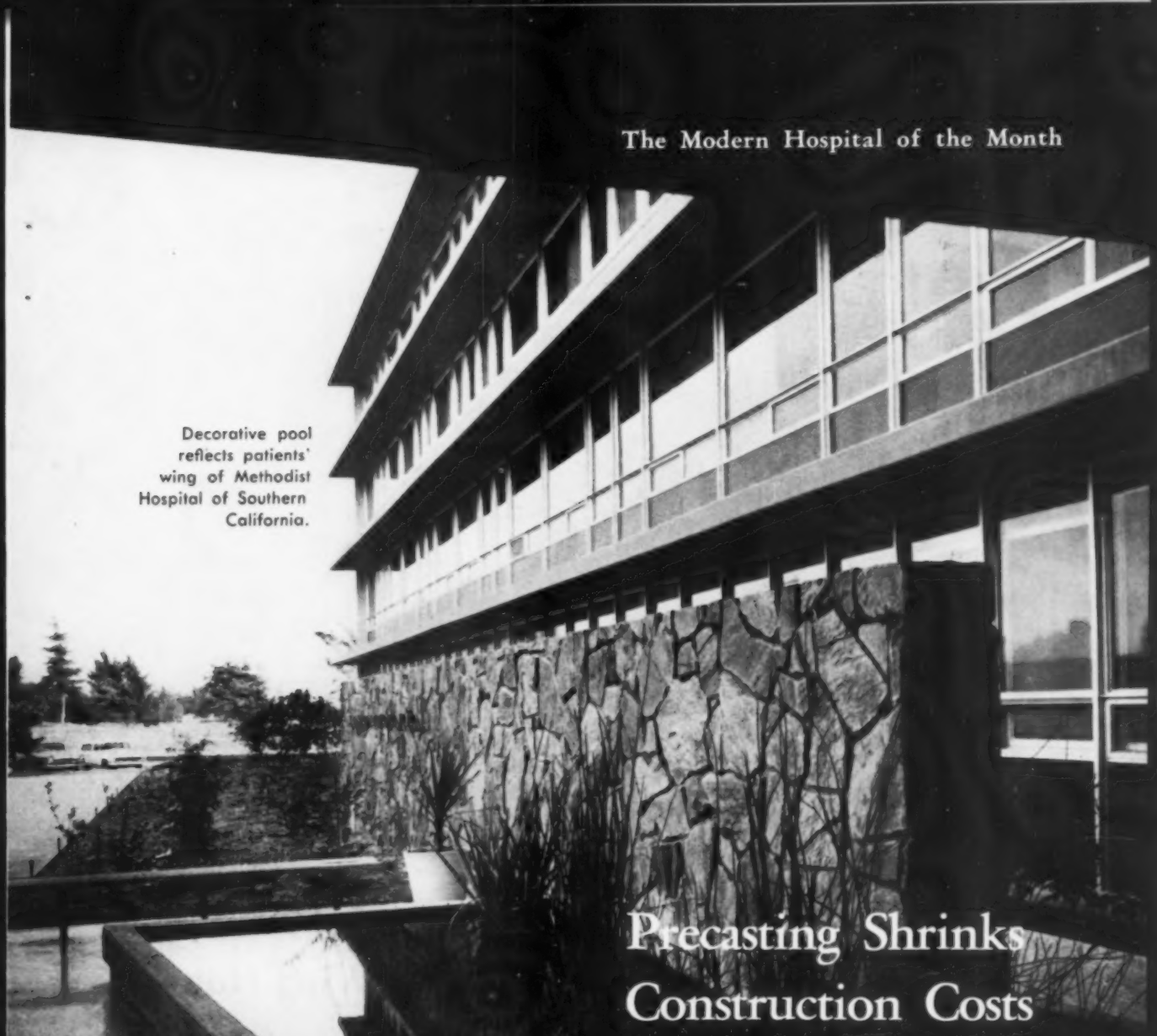
If we work to condense the three-year hospital school into two years with the stated objective of really preparing patient-side nurses who will stay at the patient's side, we could prepare one-third more workers in a six-year period, and before long instead of having nurse's aides and one-year practical nurses doing jobs for which they are not prepared, we would have an efficient, open-end structure of nurses, professional and nonprofessional, who were ethically oriented, relatively safe, and organized for service under the no-strike contracts of the American Nurses' Association. Nurses with some degree of training would then be answering the patients' phyiscal needs and answering to more responsible, better qualified nurses with considerably more education.

With educated, efficient supervisors to work under her guidance, a nursing service administrator could hope to take her place at the conference table when hospital problems, including the budget, are being discussed and to know that her control and understanding of the personnel under her jurisdiction was such that the desires of the administrator could be synchronized with the demands of the medical staff without antagonism from nursing organizations.

But nursing problems for the public will never be eliminated until nurses begin to realize that it is the nurses themselves who are causing the problems.

Fighting among themselves as to whether there will be one structural organization or two — whether non-nurse members of our organizations should or should not be allowed to concern themselves with unmet nursing needs — is not the way to win friends.

For the sake of patients and nurses of the future, we should begin to look our problems squarely in the face. The nursing problems of 220,000,000 people in 1975 cannot be handled by the same number and kind of nurse graduates we had from hospital schools in 1959. ■

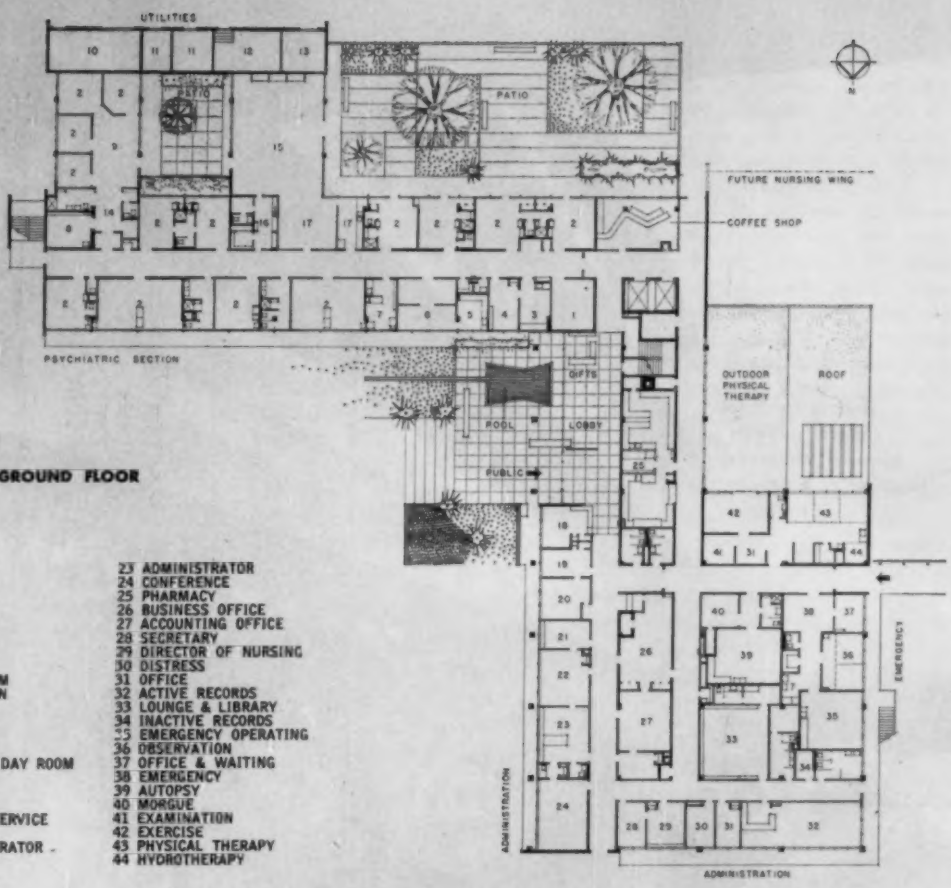


Decorative pool reflects patients' wing of Methodist Hospital of Southern California.

Precasting Shrinks Construction Costs

UP WITH the slab and down with the cost was the principle on which Architects Neptune and Thomas of Pasadena, Calif., selected the lift-slab method of construction for Methodist Hospital of Southern California at Arcadia. The technic of pouring concrete slabs for each of the four floors on the ground and raising them into position by hydraulic equipment reduced construction costs by 10 per cent, according to Walter R. Hoefflin Jr., administrator of the hospital. Another novel construction technic, which aided the cost-cutting process, was the use of precast ceramic veneer panels for the exterior curtain walls. The panels eliminated the need for back-up walls and thus reduced the weight of the exterior wall, it is explained. Plans, pictures and text describing the hospital appear on the next three pages.

First floor of the hospital houses 26 bed psychiatric unit which is built around planted patios.



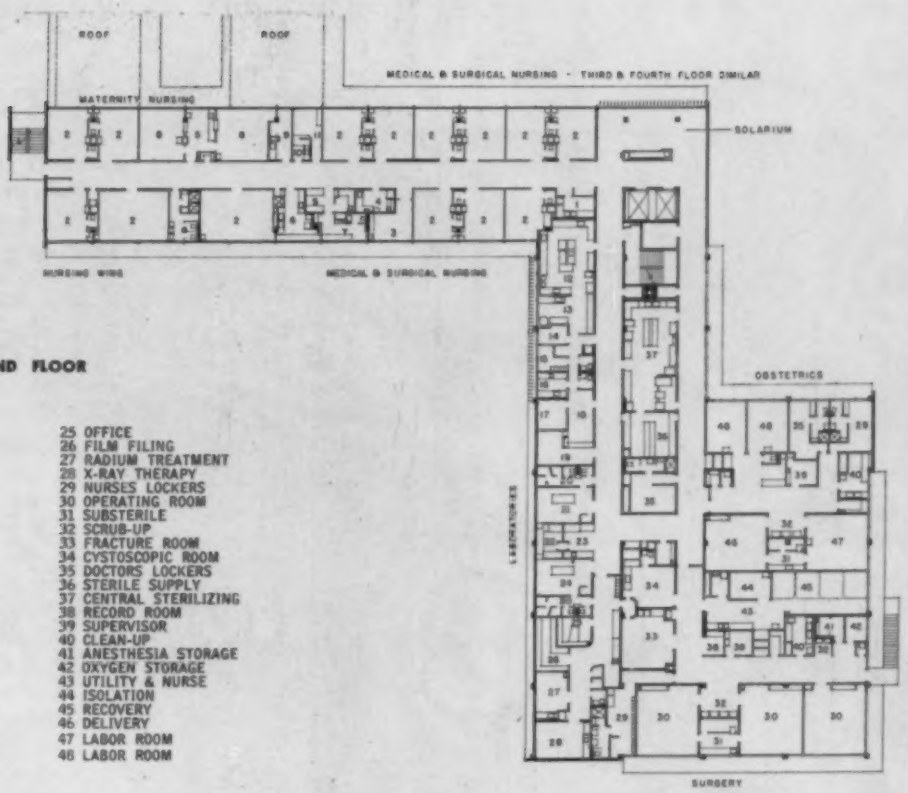
KEY TO PLAN OF GROUND FLOOR

1 VISITORS
2 PATIENTS ROOM
3 EXAMINATION
4 DOCTORS ROOM
5 SUPPLY ROOM
6 TREATMENT
7 UTILITY
8 CONTINUOUS BATH
9 DISTURBED DAY ROOM
10 ELECTRIC SUBSTATION
11 ELECTRIC PANEL
12 AIR CONDITIONING
13 STORAGE
14 CONTROL
15 QUIET & DEPRESSED DAY ROOM
16 NURSES STATION
17 DINING & PANTRY
18 RECEPTIONIST
19 MEDICAL & SOCIAL SERVICE
20 ADMITTANCE OFFICE
21 ASSISTANT ADMINISTRATOR
22 SECRETARY
23 ADMINISTRATOR
24 CONFERENCE
25 PHARMACY
26 BUSINESS OFFICE
27 ACCOUNTING OFFICE
28 SECRETARY
29 DIRECTOR OF NURSING
30 DISTRESS
31 OFFICE
32 ACTIVE RECORDS
33 LOUNGE & LIBRARY
34 INACTIVE RECORDS
35 EMERGENCY OPERATING
36 OBSERVATION
37 OFFICE & WAITING
38 EMERGENCY
39 AUTOPSY
40 MORGUE
41 EXAMINATION
42 EXERCISE
43 PHYSICAL THERAPY
44 HYDROTHERAPY

Lower Floor of Nursing Wing Houses

Patients in the four-story section of Methodist Hospital of Southern California are secluded from activities in the two-story service wing at right.

Beds in maternity unit on second floor can be used by surgical-medical patients when the need arises.



KEY TO PLAN OF SECOND FLOOR

1 SUBUTILITY
2 PATIENTS ROOM
3 EXAMINATION
4 PANTRY
5 NURSES STATION
6 UTILITY
7 LOUNGE & CHARTING
8 NURSERY
9 SUSPECT & WORKROOM
10 BOTTLE CLEANING
11 FORMULA ROOM
12 GENERAL LABORATORY
13 TRANSFUSIONS & SEROLOGY
14 BLEEDING ROOM
15 LOCKER ROOM
16 TISSUE LABORATORY
17 PATHOLOGIST
18 OFFICE
19 WAITING ROOM
20 DRESSING ROOMS
21 RADIOGRAPHY FLUOROSCOPY
22 DARK ROOM
23 LIGHT ROOM
24 RADIOGRAPHY FLUOROSCOPY
25 OFFICE
26 FILM FILING
27 RADIUM TREATMENT
28 X-RAY THERAPY
29 NURSES LOCKERS
30 OPERATING ROOM
31 SUBSTERILE
32 SCRUB-UP
33 FRACTURE ROOM
34 CYSTOSCOPIC ROOM
35 DOCTORS LOCKERS
36 STERILE SUPPLY
37 CENTRAL STERILIZING
38 RECORD ROOM
39 SUPERVISOR
40 CLEAN-UP
41 ANESTHESIA STORAGE
42 OXYGEN STORAGE
43 UTILITY & NURSE
44 ISOLATION
45 RECOVERY
46 DELIVERY
47 LABOR ROOM
48 LABOR ROOM

26 Bed Psychiatric Unit

Floor-to-ceiling windows and beautifully landscaped patios provided with garden furniture create a country club atmosphere in city hospital.

OUTLINE OF CONSTRUCTION COSTS

Total project cost		$2,688,439.00*
No. of beds	138	
(planned for 135 additional)		
Cost per bed		19,496.00*
Total square feet	77,960	
Square feet per bed	569	
Cost per square foot		26.87
Total cubic feet	883,287	
Cubic feet per bed	6,344	
Cost per cubic foot		2.37

*Includes cost of Group I and II equipment.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and the state agency. A similar award will be made each month.

Hospital in Heart of the City Evokes Spirit of the Country

Above: Roofdeck overlooking a garden court is a pleasant spot for outdoor physical therapy section. Below: Vertical blinds in patients' rooms afford a view of surrounding country and still eliminate the glare of California sunshine.

Methodist Hospital of Southern California is the first general medical and surgical hospital in the state to incorporate a psychiatric unit, according to hospital officials.

Located on the first floor of the nursing wing, the 26 bed section opens onto two enclosed patios reserved for the use of the psychiatric patients. The atmosphere of peace and spaciousness engendered by the numerous windows and the patios should have a beneficial effect on the patients and obviate any feeling of restraint, the administrator believes.

Facilities for the psychiatric patients include an occupational therapy dayroom overlooking a large outside court, consultation and treatment rooms, dining rooms, and a security department. Patients' rooms look like those in the general medical and surgical area.

The building is divided into two sections: a four-story patients' wing and an adjoining two-story administrative and service area. This design not only affords the patients privacy and seclusion but permits arranging plumbing and mechanical systems and columns in the nursing unit in uniform stacks.

Patient floors are arranged in private, semiprivate and four-bed rooms, with an examination room on each floor where patients who are sharing accommodations can be examined privately. A solarium has been placed at the end of each hall for the use of patients.

An unconventional grouping of the surgical and obstetrical divisions on the second floor makes it possible to use beds in the obstetrical section farthest from the nursery for surgical-medical patients if the need arises. The delivery suite includes a room for minor surgery in case the three regular operating rooms are in use. ■

How Labor Legislation May Affect Hospitals

Interpretations of many state and federal laws indicate that hospital administrators should recognize several new trends in labor relations

Walter L. Daykin, Ph.D.

DEVELOPMENTS in the structure and function of hospitals in the United States have been responsible for a change in attitude toward their status under recent federal labor legislation. In earlier periods, hospitals were given special treatment in the statutes that controlled industry and business or established a body of rules that defined the situation in the area of labor relations. In most instances, hospitals were exempted from coverage by the laws, or they did not come within the meaning and intent of the statutes. At present the status or coverage of hospitals is undergoing some modifications. **The present trend is to treat them more like businesses or industries as far as the laws are concerned.**

For example, hospital employes were not covered by the social security law enacted in 1935, which emphasized unemployment compensation and old age annuities and survivors insurance. However, in the 1950 and 1954 amendments to the law, hospital employes are not totally exempted from coverage. Employes of nonprofit organizations or those organized for scientific, religious, educational, literary or humane purpose can be covered in regard to old age annuities if the employer and two-thirds of the eligible employes request such coverage. This coverage is not compulsory but is voluntary in nature. The amendments to the original social security act specifically exclude student nurses and interns from coverage because they are not considered to be employes within the meaning of the law.

As yet the Fair Labor Standards Act or the wage and hour statute, which established the 40 hour work week and a minimum wage for all covered employes, does not directly apply to hospital employes. However, it is obvious that this law has indirectly affected the wage and hour conditions in hospitals. When the federal government establishes national patterns like the 40 hour week and the $1 per hour minimum wage, it is difficult to prevent these conditions from spreading into the area of uncovered establishments.

The National War Labor Board, created by executive order of President Franklin D. Roosevelt on Jan. 12, 1942, to bring about final settlement of labor disputes, asserted jurisdiction over both private and nonprofit hospitals, and in dealing with their labor problems, treated them as a business or a service industry. This board granted wage increases to hospital employes to compensate for the increased cost of living, to eliminate substandard wage rates, and to make the wages of these employes comparable to those paid for similar work in the area.

The board rejected the contention of hospital administrators that their institutions were unable to pay higher wages, and that it would be unjust to increase labor costs and then pass this on to the public. The board held that hospitals must develop practical methods to increase their income because it is unjust to be subsidized by paying low wages. Also the argument of the hospitals that they were paying the basic minimum wage established by the Fair Labor Standards Act and a comparable wage paid in other hospitals, and therefore their wage rates were not substandard, was not accepted by the board.[1] Furthermore, the board rejected a contention that it should dismiss a wage dispute between a nonprofit hospital and its employes as a dispute outside its jurisdiction, and granted a wage increase to correct interplant inequities.[2]

This board refused the request or the demand of hospital unions for the eight-hour day and 40 hour week for the health department hospital employes on the grounds that an increasing number of industries were going on the 48 hour basis owing to the war emergency.

In dealing with the matter of shift premiums the board granted this fringe benefit to registered nurses even though this was an innovation because there was no precedent for those engaged in hospital service. It was decided that such a novelty was not sufficient to prevent approval of shift premiums.(*Cont. on Next Page*)

Dr. Daykin is professor of labor and management in the College of Business Administration, State University of Iowa.

States Don't Agree on Whether To Apply Labor Laws to Hospitals

This survey of the application of the federal and state laws to hospitals reveals some significant trends that must be recognized by hospital administrators. On the federal level the War Labor Board asserted jurisdiction over hospitals and granted the nonprofessional and maintenance employes increased wages, overtime premiums, and shift premiums. It is interesting to note that in determining wage increases for these employes this board relied upon the same wage criteria, such as cost of living, ability to pay, and the going rate in the area, that are so significant in collective bargaining in industrial corporations. The federal labor legislation does not bar the unionization of hospital employes. The National Labor Relations Board functioning under the National Labor Relations Act and the Taft-Hartley amendments of 1947 has applied these federal statutes to private hospitals, in the main, in the District of Columbia, in areas where these hospitals are vital to the national defense, and to hospitals that are operated by companies that are covered by the statutes.

On the state level there is a great deal of difference of opinion as to the coverage of hospital maintenance and nonprofessional workers by the various state labor relations acts. In New Jersey, Massachusetts and Pennsylvania these state labor relations laws do not apply to hospitals, particularly to nonprofit charitable hospitals, largely on the grounds that a hospital is not an industry or an employer, the hospital employes are not employes as defined in the laws, and that labor troubles in a hospital do not constitute labor disputes.

On the other hand, the state laws are applied to hospitals in Utah, Wisconsin, New York and Minnesota because the hospital is an employer, and the workers are employes, and the laws were passed to eliminate labor troubles and thus protect the safety of the public. However, while hospital employes are permitted to affiliate with a union in these states, they are restricted in the industrial weapons, such as strikes and picketing, that can be used to elevate their status. The Minnesota law allows these employes to unionize, but it definitely prevents strikes. For the solution of labor disputes it emphasizes the importance of the establishment of a well outlined grievance procedure.

Another important trend is the change in attitude relative to hospital employes that is expressed by the various judicial and semijudicial bodies that adjudicate the cases in this area. The importance of their jobs or their role in the process of healing the sick is given much recognition. The rights of hospital employes are considered just as significant to the welfare of the community as those of industrial employes. Therefore, these employes are entitled to more privileges to elevate their status and to obtain a suitable wage structure.

However, it is recognized that when an employe accepts employment in a hospital, it is in the nature of the institution that he must give up some of the rights retained by industrial employes. Also, while boards and the courts are hesitant about permitting hospital workers to engage in strikes and use allowable industrial concerted activities, these bodies urge the development of intelligent grievance programs as substitutes for these industrial warfare weapons. ■

REGISTERED NURSES

In adjudicating the cases dealing with hospital employes the National Labor Relations Board functioning under the National Labor Relations Act passed in 1935 held that hospital employes were entitled to the protection granted to workers in the statute. For example, in the Central Dispensary and Emergency decision[5] it was ruled that the employer violated the law by refusing to recognize and bargain with a union that had been certified by the board. It was established that generally nonprofessional and nontechnical employes constitute an appropriate bargaining unit, and that the employer is legally required to bargain in good faith with such a unit.

Furthermore, this board has ruled that attendants in hospitals operated by industrial companies, in connection with their production activities, constitute an appropriate bargaining unit. The argument of one company that these employes were so closely connected or identified with management that they were confidential employes was rejected by the board. It was shown that they only had access to records dealing with the health of the employes and not those dealing with labor relations.[6] Also it has been established that nurses hired by various industrial concerns can unionize under protection of the statute, because they are not supervisory employes or representatives of management, but are employes within the meaning and intent of the law.[7]

A circuit court to which one of these cases was appealed held that the National Labor Relations Act applied to nonprofit charitable hospitals in the District of Columbia area because the activities of these organizations in supplying services and supplies constitute trade and commerce within the meaning of the statute. The fact that these activities are performed by charitable hospitals was considered immaterial, because neither the spirit nor the policy of

the act required the board to exempt charitable organizations from its coverage. Consequently hospitals were legally required to recognize the certified appropriate bargaining unit, and to bargain with the union in good faith.[8]

The Labor Management Relations Act of 1947, known as the Taft-Hartley Act, includes a number of amendments to the earlier National Labor Relations Act. Section 2 (2) of this statute states that the term "employer" does not include "any corporation or association operating a hospital if no part of the net earnings inures to the benefit of any private stockholder or individual." In terms of this section employes in hospitals not covered by the law would not be prevented from organizing into unions, but they would not be protected by the statute and would have to organize on their own economic power.

Since the passing of the Taft-Hartley Act the board has established some standards for asserting jurisdiction over hospitals and their employes. For instance, a hospital operated by an employer as an incident of operating atomic energy installation under a government contract is not a nonprofit corporation or association hospital within the meaning of Section 2 (2) of the act. The hospital is not exempt from the statute even if it operates at a loss, and any profit that might be accrued would go to the government rather than the employer. The corporation operating the hospital, rather than the hospital itself, must function on a not-for-profit basis before the hospital can be exempt from the law. In this case nurse's aides and orderlies constituted a legal appropriate bargaining unit which must be recognized by the employer.[9] Also a company owned hospital functioning on a nonprofit basis to provide assistance in case of on-the-job accidents or injuries was considered to be an employer of hospital employes because the company itself operated for profit. This was true even though the hospital showed a loss.[10]

In another case the board asserted jurisdiction over a Puerto Rican hospital corporation, which had a contract with the United States Veterans' Administration, because it operated for profit and its operations were closely related to national defense.[11] In the Consolidated Vultee Aircraft Corporation ruling[12] it was decided that a group of registered nurses was a legal bargaining unit. The company contended that these nurses could not be legitimately recognized as an appropriate bargaining unit for collective bargaining purposes because they were confidential employes. Also the employer argued that collective bargaining by nurses is against public policy and is in conflict with the code of ethics functioning in the nursing profession, and a violation of a Texas law which prohibits the representation of nurses by a labor organization which has a strike provision in either its constitution or by-laws. The board overruled all of the employer's objections and held that nurses constitute a professional group, and that the Taft-Hartley Act had jurisdiction because the state laws would be controlling only where the federal statute expressly granted the states the authority to determine such problems.

However, in a very recent decision[13] the board declined jurisdiction in a representation proceeding over a proprietary or profit hospital in New York, even though the hospital had sufficient inflow of goods from out of the state to meet the requirements established by this semijudicial body to assert jurisdiction. This ruling was based upon the grounds that such hospitals service local residents, that their operations are subject to close regulation by the states in order to protect the health and safety of their residents, and the amendments to the Taft-Hartley Act, included in the Labor-Management Reporting and Disclosure Act of 1959, make provision for state assumption of jurisdiction in situations where the board does not assert its legal jurisdiction. In such cases the state laws and court regulations will be controlling. In this decision the board implied that it had jurisdiction over private hospitals operating for profit, but that it was within its discretion as to whether or not to utilize this right in this area.

This analysis of the decisions of the National Labor Relations Board up to date reveals that this semijudicial body has asserted jurisdiction over hospitals, mainly private hospitals, located in the District of Columbia, where the operations of the hospitals vitally affect the national defense, and where the hospitals function as an integral part of establishments whose operations conform to or meet the jurisdictional standards established by the board. Where hospitals are covered by the Taft-Hartley Act, the National Emergencies Sections 206-210 of the statute which provide for an 80 day cooling off period is case of a strike or a threatened strike which would materially affect the public health and safety could be invoked.

If in the future the board interprets the Taft-Hartley Act more freely and extends its jurisdiction over hospitals, or rules that they come within the meaning and intent of the statute, material changes in the area of labor relations in these institutions will occur. The hospital workers will be permitted to unionize and form an appropriate bargaining unit. The employer will be required to bargain in good faith with the union or he will be guilty of an unfair labor practice. He will be required to bargain over wages, hours and conditions of employment. This will permit the union to penetrate into the area of managerial prerogatives. Hospital management will not be allowed to discharge employes for

Freer Interpretation of Labor Laws Would Affect Hospitals Materially

their union activities, because no employer can legally interfere with the right of workers to organize into unions of their own choosing in order to elevate their status and to obtain a fair share of the values that are produced. If the employer or administrator does discharge for legal union activities he will be forced to reinstate the employe involved to his old job or a substantially equivalent one, and to make him whole by reimbursing him for time lost.

The same reasoning applies in case of refusal to hire for union activities, because refusal to hire can defeat unionism at the threshold of employment just as discharge can defeat unionism at the exit from employment. If the administrator has an available job and a qualified employe is refused employment because of his unionism, then the hospital would have to pay the applicant for the time lost and offer him a job. To be sure, the law requires that a worker discharged illegally, or refused employment in terms of the law, must attempt to mitigate any damages created by the illegal act of the employer.

After the passing of the National Labor Relations Act in 1935 (Wagner Act) and the Labor-Management Relations Act of 1947 (Taft-Hartley Act) some 13 states passed labor relation laws somewhat similar to these federal statutes. In fact, these state laws are called "Little Wagner Acts." Some other states have no general labor relations act comparable to the Wagner Act or the Taft-Hartley Act, but they may have enacted legislation covering the right to bargain collectively and to promote industrial peace. The 13 states that have passed "Little Wagner Acts" are Colorado, Connecticut, Hawaii, Kansas, Massachusetts, Michigan, Minnesota, New York, Oregon, Pennsylvania, Rhode Island, Utah and Wisconsin. Some of these states have amended these laws since their original enactment. With the exception of Connecticut none of these states specifically exempt charitable hospitals from coverage under their statutes.

A study of the rulings in states that have enacted labor relations statutes reveals that there is a difference of opinion relative to the application of these statutes to hospitals and their employes. For example, the Utah supreme court has ruled that the Utah Labor Relations Act is applicable to charitable hospitals and nonprofessional employes. The court rejected the contention or argument that the law did not cover charitable hospitals because hospital business affects interstate commerce and is therefore subject only to federal legislation. The court stated that Congress had not occupied this area and had not prevented state regulation.[14]

The Wisconsin Employment Relations Board functioning under the Wisconsin Employment Peace Act has ruled that charitable hospitals and their nonprofessional workers are subject to the state labor relations statute. The charitable hospital is an "employer" and the nonprofessional employes are "employes" as defined in the law. Consequently the hospital is legally bound to bargain collectively with the union.[15] Both the Wisconsin circuit court and the Wisconsin supreme court have substantiated the board's reasoning. The circuit court has decided that the Wisconsin act applies to hospitals because there is no provision in the statute for exemption of hospitals, the hospital is an employer, and the nonprofessional workers are employes within the statutory definitions contained in the law, and the application of the statute is not limited to employers and employes in an enterprise operating for profit.[16] If the hospital refuses to bargain with the certified union it would be guilty of an unfair labor practice.

The Wisconsin supreme court has affirmed the circuit court ruling. This higher court held that charitable hospitals are not within the named exceptions contained in the statute and that the words of the statute are broad enough to cover these institutions. In answering the hospitals' argument that if the law was applied to their charitable institutions the patients would be endangered, the court stated that the purpose of the law was to promote peace and not to create strikes. It was argued that the kitchen help in hospitals should be permitted to use legal devices to unionize and to obtain better wages and conditions of employment.[17]

In other decisions the circuit court of Wisconsin has ruled that the employer or hospital administrator violated the Wisconsin statute by refusing to bargain with the union. Also the act is applicable to the hospital and its nurse's aides. It is not inapplicable on the grounds that the hospital is engaged in caring for the sick. The hospitals have been forced to reinstate employes who have been discharged because of their engagement in legitimate union activities.[18]

It has been ruled that the New York labor relations act is applicable to maintenance and service employes working in a hospital privately owned by a physician and operating for profit. It was reasoned that the statute was not intended to apply only to industrial establishments. The board negated the contention that unionization and its concerted activities would lower the efficiency of operations and affect public health and safety negatively, because the law was originally enacted to eliminate the danger and inconveniences of labor troubles.[19] The New York board has also asserted jurisdiction over a private hospital where the services rendered were primarily local in nature, despite the fact that the hospital was part of a chain of hospitals engaged in interstate commerce because each hospital in the chain functioned as a separate and distinct entity. Consequently the maintenance workers, kitchen helpers, and housekeeping employes could legitimately join a union of their own choosing.[20]

On the other hand, the New York

board has declined or refused to assert jurisdiction over a company that operated a private or proprietary hospital on the grounds that its annual gross income met the jurisdictional standards established by the National Labor Relations Board.[21] Also the New York board declined to take jurisdiction in complaint cases that involved a private nursing home and hospital largely because the institution was functioning in interstate commerce, and the N.L.R.B. had not made it clear as to the revised jurisdictional standards it would apply to hospitals.[22] Perhaps this question will now be solved since the amendments contained in the Labor-Management Reporting and Disclosure Act of 1959 permit the states to assert jurisdiction in cases where the N.L.R.B. declines to.

In reviewing the cases, the New York supreme court has sustained the decisions of the New York board relative to the application of the state statute. This court has agreed that the New York act must be given a liberal interpretation. Therefore, this law could be applied to a private hospital operating for profit, and this hospital must bargain collectively with a union composed of service and maintenance employes. The court rejected the reasoning that the statute was meant to apply to the broad fields of industry alone, and that its application would be detrimental to public health and safety.[23]

However, while the New York supreme court has permitted hospitals to be covered by the state statute, this judicial body has restricted the use by unions of various concerted activities developed in the area to elevate the status of employes. This court held in the Society of the New York Hospitals *v.* Hanson case[24] and the Beth-El Hospital *v.* Robbins case[25] that a charitable nonprofit hospital was entitled to an injunction to prevent striking by nonprofessional employes to compel bargaining. While the New York statute regulating or relating to labor disputes does not specifically forbid strikes by employes in charitable, educational and religious institutions, it does exempt these charitable institutions from the obligation of bargaining collectively with their employes. A strike in this area is illegal because society cannot tolerate or justify work stoppages that would hinder or interfere with the caring for the sick. It was emphasized that policemen, firemen and soldiers do not have the right to strike because of the close relationship of their employment to the public interest. It was contended that when a person accepts a job in an area which directly involves public interest he must give up many of the rights retained by employes in private industry.

It is interesting to note the legal and subjective reasoning of the court in these cases. It was stated that the dispute was not one-sided and that the plight of the workers necessitated some help. The workers had the right to bargain and to attempt to elevate their status, but this must be accomplished through means which will not impair or harm the public health. Also it was emphasized that the mercy and charity of the hospital should be extended to the basement and the lowliest workers in its employment. In other words, the health of the workers must be maintained by

(*Continued on Page* 124)

New Labor Law Follows Taft-Hartley Pattern

The Labor-Management Reporting and Disclosure Act of 1959, [Section 3 (e)] in defining the term "employer," does not specifically exempt charitable hospitals, as does Section 2 (2) of the Taft-Hartley Act, from its coverage. It is important to note, however, that this new law regulating labor relations in defining an employer does follow the pattern of the Taft-Hartley Act and exempts the "United States or any corporation wholly owned by the Government of the United States or any State or political subdivision thereof." Also this new legislation in Section 203 (b) (2) authorizes the secretary of labor to determine or to prescribe how the information to be included in the report of employers shall be categorized.

Obviously this raises the question as to whether the statute does or does not apply to hospitals and their union employes. This matter of coverage of hospitals will initially be determined by the National Labor Relations Board and the secretary of labor, and finally by the appropriate courts.

If hospitals are not exempted from coverage under this new legislation, legally certified or recognized unions in this area will be required to respect the bill of rights outlined in the law, to make the designated reports in the prescribed manner, and disclose the required facts to the secretary of labor. Moreover, in terms of Section 203 of this law, hospital employers or administrators will be obligated to report any loans or payments made to union representatives, and payments made to employes or expenses incurred for the purposes of influencing the worker's right to organize and to bargain collectively. Also the hospital employer will be legally required to report any arrangement with labor relations consultants for the same purpose, or for supplying information on employes or the union during the labor dispute.

Any consultant who engages in such work must also report the receipts and disbursements in connection with any labor relations activity. In dealing with employers' expenditures to influence the employes' use of their right to unionize, this section includes any expenditures which would "interfere with, restrain or coerce" employes in this statutory right. The union and the employer are subject to criminal penalties for failure to make the required reports. ■

Labor and management have largely determined the scope of bargaining

Does Collective Bargaining Usurp

James W. Kuhn, Ph.D.

IF STUDIES and surveys give a true picture of how hospitals operate, administrators are threatened or ignored by doctors, obstructed by nurses, instructed by boards of trustees, flouted by technicians, condemned by social workers, and bypassed by housekeeping workers. Further, the administrators are required to run a combined charitable, business, public service, educational, and research institution – and to run it, of course, with efficiency, harmony and dispatch on an insufficient budget and with a shortage of personnel and inadequate facilities. Hence, it is not to be wondered at that hospital administrators have a lively concern over the effects of collective bargaining on their right to manage.

The prospects of piling collective bargaining, negotiations with union officials, and grievance hearings on top of the hospital administrators' already heavy load may well appear to be too much. Collective bargaining apparently promises a dismal task for the administrator personally and an essential impairment of his official role. No one who knows anything about industrial relations can have any illusions that collective bargaining has not had or will not have a decided effect upon managerial activities. It is not so much a burden weighing down management, though, as it is a checkrein upon management freedom.

Whether managers deal with unions or not, they must perform most of the activities and duties with which collective bargaining is concerned. Managers must set wage scales, evaluate jobs, determine work loads, fix personnel policies, and administer discipline, promotions, hirings, firings and transfers. A wise manager will have some arrangement for handling and hearing grievances and for taking care of the problems of vacation, health, safety and retirement programs. If these personnel policies and programs have been well conceived, they will have been thoughtfully enacted and carried out. The study and debate preceding their enactment is not unlike that of collective bargaining. However, the freedom with which the work is performed is different and so is the status of the managers. Under collective bargaining, the employes and their representatives help determine personnel policies, injecting some of their values into the considerations – and thus challenging management's rights and prerogatives.

To see in collective bargaining a challenge to managerial rights is nothing new or recent.

In 1951 the C.I.O. adopted a resolution which must have appeared to managers to confirm their worst fears of what the unions were about. The resolution called for an equal sharing by union and management in price determination, production levels, rates and nature of capital investments, size and location of industrial plants, and the development and conservation of natural resources.

More significant than the fears of the business managers and the vistas dreamed of by the more radical union leaders in 1951, are the realities of union infringement of managerial "prerogatives." To move from excited union demands and alarmed management statements to the actual results of collective bargaining is to move from a world of fantasy to the work-a-day world of tough but not insurmountable problems.

For example, not three months after the breakup of the Labor-Management Conference of 1945, General Motors successfully rebuffed strong union demands to negotiate over its pricing policy. After a 113 day strike, General Motors not only maintained its control of pricing but forced the union to settle for a wage increase lower than that recommended by a government fact-finding board. While the cost of the strike in 1945-46 may have been a high price for General Motors to pay for its control of its prices, the company has suffered no major strikes during the intervening 14 years and management runs the corporation; there is no doubt in union leaders' minds about that.

The problem of the "right to manage" remains with us, despite the strong stands taken by some managers. In times of a tight labor market, rising prices, and easy money, when increased costs and prices are easy to pass on, managers have not always been willing to resist union demands to add a bit more control of jobs, work or employment. The unions do not push massively and inexorably into vital policy areas. They push only when and if they can, advancing when management is

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the Manager's Right to Manage?

careless and weak, retreating when management aggressively resists. Not even the C.I.O. unions did anything substantial to implement their 1951 resolution.

"Right to manage" has become a publicized issue — and has been complicated because it is not just a private matter of collective bargaining, but is also a public matter before the National Labor Relations Board and the courts of review involving it in public debate and controversy. Decisions of these high governing bodies have affected managerial rights — usually by approving the widening of the area of collective bargaining. Charles E. Wilson, when president of General Motors, once said, "As long as the law is not clear on this issue [of managerial functions] the unions will feel that they are justified in their efforts to drive ahead, [pressing the boundary farther and farther]." He was probably right, but the National Labor Relations Board members and court justices have no clear guides to follow. Congress has purposefully spoken in the Wagner and Taft-Hartley acts with words as subject to multiple interpretation as those of the Delphic oracle.

The basic labor law of the land requires unions and management to bargain in "good faith over wages, hours and other terms and conditions of employment." Such a phrase sounds reasonable and traditional, but, under the logic of legalities and of political policy, words do not always mean what they appear to.

How far collective bargaining can go is suggested by the Richfield Oil Company case.[1] The company was required to bargain over a stock bonus plan that it had initially set up. The company maintained that stock could not be considered wages, for it was not compensation for work performed but merely an incentive to employes to invest in the company. The N.L.R.B. found, however, that wages is a broad term, including all emoluments of value which may accrue to employes because of their employment relationship. The court upheld the board's right to make such a decision.

Hospitals are not likely to offer stock bonuses to their employes, and if they did, the employes would not be likely to care for ownership in a nonprofit organization. The case illustrates, though, how deeply collective bargaining may touch areas usually thought of as peculiarly managerial.

Needn't Grant Concessions

In its decisions the Supreme Court has emphasized what the law clearly states, that having to bargain in good faith does not mean that management has to make concessions to the union. Certainly just because profit sharing is a bargainable issue, the U.A.W. did not secure it from Ford or General Motors two years ago. Nor have other unions found it easy to secure. The only demand made by unions that the board and courts did probably help the unions to secure was that of pensions. Inland Steel took the matter to the federal courts and lost; the company had to bargain over the issue. After bargaining, the company agreed with the steel workers to a pension plan. Shortly thereafter, pension plans blossomed in hundreds of labor agreements in all sections of the country.

The general opinion of labor students would be, I believe, that despite some startling decisions of the board and some surprising decisions of the courts, labor and management have determined the scope of collective bargaining themselves. Whether the government had interpreted the law narrowly or broadly, the natural evolutionary course of bargaining over the years would have extended the subject matter and coverage of the labor agreement and the union's interests. Managers have always been free to go beyond the requirements of the law if they so desire or are forced to. Unions and management generally have decided upon the scope of collective bargaining and the degree of union participation in traditional management areas on the basis of economic realities of their own situation.

Anyone familiar with the history of collective bargaining uses the term "rights of management" cautiously, and the term "management prerogatives" makes a student of labor uneasy. We shy away from these terms not just for ideological reasons or because we do not recognize distinct managerial functions. We shy away because unions have limited these "rights" and "prerogatives" progressively for many years, yet no evidence suggests that management's functions have been impaired. Ameri-

[1] 110 N.L.R.B. 356, enforced C.A.D.C. Jan. 26, 1956, 37LRRM2327.

can management today is probably more effective and efficient than it was 15 years ago, and certainly much better than it was 50 years ago before unions were important. An observer might well conclude that management has improved, not despite the unions, but with the aid of the unions.

In marked contrast to their public statements, managers do not privately complain that collective bargaining imposes significant restrictions upon them. Some may annoy managers, but if they seriously interfere, managers find ways to change or get around them. In a recent study of 51 Midwestern firms,[2] researchers could not find evidence of much enlargement in the area of joint decision making since 1945 — if there had been any at all. The managers of these firms were not seriously concerned with the degree of union penetration of their managerial areas. The union leaders showed little interest in taking over managerial duties; they have concentrated upon those areas that most directly affect jobs and wage rates.

The realities of industrial relations indicate that managers cannot have many real complaints about the erosion of their rights and that union leaders will not take over managerial activities. Managers work within restrictions, union or no union. When transferring workers from one job to another, a personnel administrator will wisely consider skill, seniority and the response of the work groups affected. The presence of a union requires only that the manager act within the limits of established policy, not capriciously or arbitrarily.

Union participation in establishing policy is not a new limit upon management's powers. Managers participate in joint decision making with workers and with work groups all the time, even in the absence of a union. Unless there is a supervisor for every cleaning woman, the housekeepers will help decide how quickly corridors and wards are scrubbed. The elevator operators, not doctors or nurses or personnel administrators, determine the speed and dispatch with which patients are moved from floor to floor. The employes in the kitchen help determine how hot food is when it arrives at the bedside. A hospital administrator, like his industrial counterpart, determines pace and quality and efficiency of work only within limits — and only with the approval and cooperation of the workers.

Pace, quality and efficiency of work are not unimportant "managerial" areas. In industrial plants workers on piece rates often decide to work faster during early shift hours in order to loaf during the last half of the shift. The resulting surges of production require management to provide extra, costly storage space. The high speed use of tools and machines causes greater wear and thus faster deterioration and high maintenance costs. In hospitals, too, even lowly workers can make basic decisions for the whole organization. Should aides not clean water pitchers and hence allow them to become reservoirs of staphylococcus, they can raise the death rate of the hospital — a basic and serious decision.

The unique function of management is not its decision making power, for this is too widely shared, but its requirement to coordinate and balance off all the multitudinous demands made upon the organization. In a business firm, the manager must reasonably satisfy the demands of shareholders, banks and money lenders, customers, suppliers, retailers, government agencies, and contractors as well as employes. Each demand must be met in a way that is consistent and compatible with all the other demands. If a firm is to grant a wage increase, the manager must cut the cost of supplies, introduce labor saving equipment, charge higher prices, or reduce the profit margin. Unless he can make one or more of these changes without undue penalty, he is not likely to grant any wage increase.

A union demand for a wage increase may make the manager's job more difficult, but it does not make the manager less a manager. He is challenged to work within his budget restriction, and the constraints of other insistent demands made upon the firm, and still achieve *his* goals and those of the organization. Unions challenge the ingenuity of managers rather than managers' prerogatives. Unions take no responsibility for satisfying all the various demands made upon the firm — that is management's alone.

I suspect this restatement of managerial functions is small solace to

[2]Derber, Chalmers, Stagner: Collective Bargaining and Managerial Functions: An Empirical Study. *Journal of Business*, 31:107, 1958.

The Workers May Determine Final Limits

Though collective bargaining has expanded into new areas during the last hundred years and particularly during the last 30 years, we should not conclude that there are no limits to joint union-management decision making. The union is a political body with frequent changes in leadership at the local level.* Local leaders are responsive to their constituents, or they had better be, if they want to stay in office. Since union members, like most American voters, are somewhat apathetic about voting unless they have a specific complaint against a candidate, they are more likely to vote against a man than for him. Accordingly, union officials prefer to avoid issues that can give rise to intra-union disputes and force them to take sides against some members.

A union negotiating committee in a metal-working plant in New York, for example, boldly demanded and obtained from management the right to establish rate differentials among work crews using the same tools and machines. The committee awarded one crew a special 1½ cents an hour differential based on its higher productivity. In the words of the union president: "Then, all hell broke loose! We got all

*Sayles, Leonard R., and Strauss, George: *The Local Union*. Ch. 10, New York: Harper & Bros., 1953.

of Labor-Management Decision Making

the blame they'd have leveled at the company if it had set the rate." At the next election, disgruntled members elected a new negotiating committee and the union wisely turned the job of setting rate differentials back to the company.

In a large Midwestern plant a similar illustrative incident took place. The union joined management on a joint board whose purpose was to determine the skill classification of various jobs. All workers wanted their jobs classified as skilled because a skilled job was especially protected against "bumping" during lay-offs. Every group of workers began to agitate for its claims. The union was racked with intrigue and dissention. No union member of the joint board dared give final approval to any claim for fear of antagonizing too many other claims. After 18 months of frustration the union withdrew from the board and went back to its politically feasible work of "grieving" management's decisions on classification.

Such incidents as these two can be multiplied many times. They suggest that while one cannot draw hard and fast lines between union and management activities, union leaders will not wish to extend their activities in the plant forever. ■

managers; I should hope, however, that some of the overemotional content of the dispute about the "right to manage" might be drained away. Let us look critically at union demands and union participation in decision making; let us examine the contributions of unions as well as their restrictions.

The dangers of union participation in joint decision making arise more frequently at the lowest level than at the top. The supervisor immediately above the workers can do much to turn a plant over to the union. For example, a foreman in one steel plant gradually dropped the practice of requiring his skilled millmen to work in their spare time sealing cracks around the annealing furnace doors with sand. After the war, when the company drew up new job specifications, the foreman neglected to include sand-sealing in the millmen's job. Last year, in an attempt to cut labor costs, the plant superintendent asked the men to seal sand once again. The men refused, claiming that a past-practice precedence had been established; only laborers could now sand-seal. The arbitrator agreed, and now when a sand-sealer is needed, if only for two hours a shift, as is often the case, the company has to hire a laborer and pay him wages for a full shift.

Of course, soft-headed managers can inflict a terrific loss upon their firm, too, by following soft-hearted personnel policies. In a New Jersey firm, an amiable director of personnel agreed to a labor contract that allowed the plant's 18 shop stewards full pay for full-time looking up — or cooking up — grievances. The cost of this agreement in salaries, nuisance grievances, and wasted, fruitless grievance meetings was at least a quarter of a million dollars a year.

Managers must recognize the implications of their agreements, and they must be constantly alert to the dangers of saddling themselves with costly, inflexible practices. The lower level supervisors, too, must be aware of the dangers of inattention to precedent setting practices that can easily become restrictive rules. Collective bargaining and negotiations with unions require what any organization ought to have anyway — able, dedicated, alert and energetic managers, managers who stay on top of their jobs.

In those areas where union leaders are active, continuing participants in decision making, however, managers can use the union to their own great advantage. Foremen make frequent use of shop stewards. Often, more effectively than foremen, stewards can persuade workers to agree to overtime work, to help put through a special order, or to exert extra effort to meet an unexpected deadline. Plant managers frequently find union leaders more effective than any supervision in combating poor safety records, absenteeism, lateness and poor quality work.

Managers can use the union and its officers not only to achieve better production and services, but also to help combat the threatening demands of other groups within and without the firm. A knowledgeable foreman who knows that he cannot meet his production schedule without an extra man on his line may provide the union leaders the opportunity of using their greater bargaining position to convince the production engineers of their error. Union grievances complaining against unreasonable pace, health and safety on an undermanned line, or the foreman doing production work, may be more convincing to higher management than a whole stack of requests from the foreman for an extra man. Or a personnel manager, bothered by a high level supervisor flouting company policy, can see to it that that man has the embarrassing and difficult task of defending his errors before the union grievance committee and an arbitrator.

Perhaps of most importance to hospital administrators is the fact that added power and authority must accrue to those who negotiate with the union. A centralized, uniform administration of labor and personnel policy is necessary when management deals with unions. Without it, the union can whipsaw the different authorities within the managerial hierarchy and make a shambles of any authority. Some *one* office must control personnel policy.

If it is true that hospital administrators are sorely beset by demands from a multitude of professional groups within the hospital and mightily squeezed by the pressures of the multiple purposes that the hospital must recognize, collective bargaining may well offer an opportunity for them to exercise their "right to manage" with greater freedom than ever before. ■

Policy Manual Keeps Administrator Informed – and Out of Trouble

Charles M. Martin

A POLICY manual for the board of trustees can save a great deal of time for both board members and administration and prevent a great many wrong decisions.

In addition to assisting the board and the administrator in this fashion such a manual provides both with a ready reference.

What is the board policy (re: staff by-laws) regarding consultants from neighboring communities? How many department heads may be absent from the hospital at any one time? Why didn't the administrator get board approval before purchasing a particular piece of equipment which cost $400? And why didn't he solicit formal bids?

These and many other questions will arise from time to time at board meetings. The answers can be readily answered one way or another by reference to the manual. If the board has it available for ready scrutiny, lengthy and often inconclusive discussions can be avoided.

Once established it must be faithfully maintained. The process of establishing such a manual will be an education for both the board and the administrator. Both may be surprised at just how little in those voluminous minute books may relate to statements of policy or are specific instructions for the guidance of the administrator. Few administrators are in a position where they can tell their boards that a decision on the subject matter is administrative detail rather than formulation of policy. Any administrator may, however, inquire as to whether the decision, when reached, is to be considered a statement of policy which will be appropriately included in the policy manual. In this light the board can answer the question for itself.

Mr. Martin is administrator of San Juan Hospital, Inc., Farmington, N.M.

Such a manual also offers the board a better opportunity to be consistent over an extended period of time and provides form and continuity in the administration and operation of the hospital. Since the manual reflects the thinking of the board over a period of time it becomes in a sense a historical document. The board, as individuals and as a group, can review past decisions and decide whether or not under the changing circumstances of time and economics of the community a particular policy should be amended in any way. Many communities in recent years have changed from small rural communities to bustling urban or industrial centers. Collection policies which were satisfactory five years ago may no longer be desirable and consequently must be changed. While the institution was small, as was the medical staff, the establishment of formal admission policies might have been not only unnecessary but even undesirable. However, since the hospital and the size of the medical staff have kept pace with the growth of the community, formal admission policies which outline such things as admission procedures, bed reservations, movement of patients from one floor to another, and the like are now essential for smooth operation of all departments.

A manual serves as an excellent tool for the orientation of new board members. It gives the new board member an instrument by which he can begin his orientation to the hospital and its operation, and, depending on the age of the institution, over a period of time by reviewing all the statements of the board with included amendments, he will be able to get an idea of what action the board has taken in various spheres and in what direction. It would serve to orient not only a new board member but also the new administrator, since from time to time hospitals change administrators.

Every administrator is at one time or another subjected to pressures from individuals in the community to make "bread and butter" purchases at prices which are not competitive with other "outside" sources of supply. Or there may be the doctor who wants the hospital to forget the cash requirement for a particular patient. There is always one doctor who doesn't want to get his charts up to date because it is so much work, and why can't the matter just be overlooked or ignored? How many times has a patient tried to pass off an insurance policy on outpatient work when cash is called for and comes in to the administrator to tell him all the reasons the insurance policy should be accepted in lieu of cash. And once in awhile a particular board member may suggest that the administrator should maintain additional records for special information in which the board member is interested (such requests become cumulative and expensive).

Since the manual is a ready reference the administrator can point out, where apropos, that since many of these things are matters of board policy and his prime responsibility is to carry out the wishes of the board, his hands are tied until or unless the board decides to revise the policy or issue a directive on the particular matter.

The human mind is far from infallible and memory is not a good substitute for a handy written record. One area where recollection is an extremely poor foundation for conduct on the part of the administrator is in the use and changes, major or minor, that he may make in the physical plant. One year the chairman of the building committee may be easy going and orally delegate to the administrator the authority to do almost anything he pleases with the building. The next year the chairman may be new and ask some very pointed questions as to who gave the administrator the authority to raze the walls to enlarge central supply, the laboratory, or the administrator's office. It is well to have the board outline the areas of the administrator's authority to proceed without prior authorization or surely sooner or later there will be trouble. ■

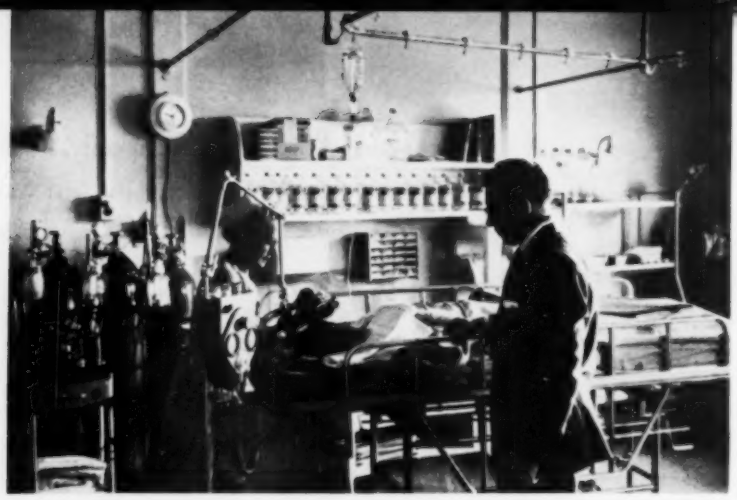
A year's experience has convinced Grant Hospital, its staff, and patients that progressive care is the best way to provide patients with individually "prescribed" care at reasonable cost

Patients Vote for Progressive Patient Care

IF LUCILLE RIESCHL, assistant head nurse on the intensive care unit at Grant Hospital, Chicago, ever entertained any doubts about the value of the hospital's progressive patient care program, they vanished when she became a patient and went through all three phases – intensive, intermediate and ambulatory – herself. Her adventures with progressive care, from the time an antisocial appendix landed her on the operating table until she was back on the job, are recorded in pictures and text on the following four pages and this month's cover.

Patient's progress starts on the operating table. A monumental stomach ache brought Lucille Rieschl, assistant head nurse in the intensive care unit, to Grant Hospital as a patient. Diagnosis: appendicitis, with trimmings; surgery indicated.

Everything is there for intensive patient care



Above: Following excision of the offending appendix, Miss Rieschl was taken to the postoperative recovery room. Here, Velma Dale, supervisor of the unit, applies an intermittent positive pressure mask as a doctor stands by.

Above: Next stop for Miss Rieschl was the intensive care unit. Grant Hospital has three 6 bed rooms in this section. Nurse assistant in foreground checks patients' charts at standing-height desk. Below: Waiting room for patients' relatives can be converted to intensive care use if extra space is required.

In the central nursing station that serves the intensive care unit, Dr. Lindon Seed checks Miss Rieschl's chart with Laura Ververs, head of the unit. All supplies, equipment and linens necessary for the care of the patients are stocked in the nursing station to be available at all times.

DOCTORS ASKED FOR THIS PROGRAM

Miss Rieschl's enthusiasm for the progressive patient care program at Grant Hospital is shared by her colleagues on the nursing and medical staffs and by other patients. The program was inaugurated at Grant in July 1959 at the specific request of the medical staff, hospital officials say, and the interest and support of the doctors has made it a success from the start.

Groundwork for the program was laid when representatives of the medical and nursing staffs and the administration went to Manchester, Conn., to study the progressive care program at Manchester Memorial Hospital. When they returned, Dorotha Edgeworth, associate director of nursing, explains, they made a detailed report to the staff on the advantages, disadvantages, problems and benefits that could be anticipated.

Once they had accepted the idea, the medical staff members proceeded to establish safeguards to control utilization of the three divisions

Progress is being made as Miss Rieschl takes her first step to recovery, via wheel chair, her baggage on her lap, as student pushes her from the intensive area to the intermediate unit.

Above: It wasn't a long trip to intermediate care but Miss Rieschl climbs thankfully into the bed that has been prepared for her. Below: She's almost well. In her room in the self-care section, Miss Rieschl reads with her feet up. "This is the part I liked best," she reports. "They let me sleep late."

CHARGE FOR INTENSIVE

and appointed a Progressive Patient Care Control Committee to govern all areas of the program and maintain liaison among the nursing department, the medical staff, the trustees, and administration. One rule, for example, states that stay in the ambulatory area is limited to 15 days.

Thus far, Dr. William E. Hutchison, medical director, reports, there have been no serious violations of the regulations. And, he adds, "our doctors wouldn't go back to the other system." Dr. Hutchison considers the ambulatory area "our best public relations" for the hospital. Self-care, he says, prepares the patients to resume normal living; it helps them gain strength, and gives them a psychological boost.

Dr. Hutchison and Mrs. Edgeworth are equally enthusiastic about the intensive care area. They have found that the doctors have the comforting assurance that their patients are getting the best care because the nurses are trained to deal with all emergencies.

Self-care patients, Miss Rieschl among them, take their meals in an attractive cafeteria-lounge where they can not only eat but play cards, read or watch television as they wish. Meals are served at regular hours, but a refrigerator behind the counter is kept stocked in case somebody wants a snack.

Back in business. Fully recovered and full of enthusiasm for progressive patient care, Miss Rieschl returns to duty as head nurse on a ward in the intermediate care unit where her services were needed.

CARE SERVICE REDUCED

The patients' views were summarized by a patient in the self-care unit who took time out from watching television to state: "This is the greatest advance medicine has made in the last 50 years. I've been all through the mill – and I know."

Careful cost studies have been made since the inception of the program, and charges to patients have been adjusted on the basis of experience. When the plan was inaugurated, rates in each of the three divisions were: intensive care, $42 per day; intermediate care, $22 per day (average), and self-care, $16 per day.

After a year of operation the rate for intensive care was reduced to $39.50 per day and the rate for self-care was raised to $16.50 – a net gain of $2 per day for the patient who "goes all through the mill."

A study of the Grant Hospital program, with emphasis on training and organization of personnel, was started by the Public Health Service last month. ■

Caps worn by nurses at the hospital were displayed with signs identifying various schools represented. The poem, "My Cap," is reproduced on center panel.

Panel showing hospital statistics, an employe's collection of bells from the hobby show, and an exhibit of antique pharmaceutical equipment were used in this varied display.

Display Case Shows the Hospital's 'Wares'

Marjorie Saunders

A DISPLAY case in the hospital can be an effective public relations tool if it is used wisely. Finding a convenient location for the display is often a problem, however.

At Baylor Hospital, Dallas, the problem of providing a display area was solved when some remodeling was being done. Between the visitors' area and the pharmacy was a ramp, bordered on one side by unattractive iron bars to prevent small children from falling down the ramp from the visitors' area.

In the remodeling, a stone planter box was substituted for the iron bars and filled with artificial plants. This provides a better restraint for children and also provides a display area in the wall to the side of the ramp.

The display case recessed in the wall has sliding glass doors and removable, adjustable glass shelves on each side of a center panel. The entire back of the display area is corkboard to facilitate use of photographs and charts.

This display case has been in constant use since it was completed. We have used many different exhibits, all of which have been received enthusiastically by both employes and the public.

One exhibit featured student projects in the nursing care of children. The center panel showed photographs of student nurses making some of the objects displayed, with an explanation of the purpose of the projects. On the shelves some of the actual objects were displayed.

One of the most popular exhibits was a display of nurses' caps worn in the hospital. Each was identified as to the school of nursing represented. Another popular exhibit was one on occupational therapy. The center panel showed photographs of patients engaging in different occupational therapy activities. The shelves displayed items made by patients.

Some departments have used the center panels still further in displays outside the hospital and some have hung the panels in their offices for visitors to see; still others have used them in teaching.

We believe hospitals that are not using displays as a public relations tool will find it worth investigation. If space seems to be a problem, a survey of facilities may reveal a spot that can be converted to this purpose with a minimum of expense.

At Baylor, we believe our display area is playing a vital role in telling our hospital's story to our visitors. ■

Marjorie Saunders is director of public relations, Baylor University Medical Center, Dallas.

Research Puts Meaning Into Cost Comparisons

A detailed study of charges and departmental costs in six Southern hospitals included personal visits to ensure uniform reporting and reliable comparisons

C. H. Hottum Jr.

ALARMED by the continuing increase in the cost of hospitalization, the board of trustees at Methodist Hospital, Memphis, Tenn., was anxious to make a detailed comparison of charges to patients and departmental costs among hospitals of similar size (300 to 500 beds) in the South.

When the board embarked on this project, however, it discovered that the available comparative figures for such hospitals contained gross discrepancies and were generally unreliable.

The board then authorized a more exhaustive and accurate study.

General hospitals in Tennessee, Louisiana, Texas and Arkansas were invited to participate. To make the study as accurate as practical, it was decided to schedule visits to each of the participating hospitals so that any variations in reporting could be investigated and explained. **The figures to be used were for the six-month period ended June 30, 1959.**

Upon acceptance, each hospital received a questionnaire together with extensive explanatory notes. These notes provided detailed instructions for allocating patient income and expenses, and listed by department the salaries that should be included in operating expenses.

As Exhibit A indicates, only depreciation allocable to patient care was included in the study. Depreciation cost allocable to other operating income (such as doctors' office building, retail drug store, and so forth) was eliminated.

Total patient income was departmentalized on the questionnaires and then segregated between outpatients and inpatients so that only inpatient income was left in the study (see Schedule 1 on next page). Salary cost by department was also reported (Schedule 2 on page 83), as were supplies and expenses. The portion of direct cost allocable to outpatients was eliminated by departments, based on the percentage of outpatient income of each department to its total income. For example, if 25 per cent of x-ray income was attributable to outpatients, then 25 per cent of x-ray salaries and supplies and expense was eliminated from the study.

The visits to the participating hospitals enabled the researcher to review the gross figures at each hospital and reclassify, where necessary, in an attempt to assure uniformity. Then, average per diems for adult patients on income, salaries and supplies, and expense by departments were computed. As the accompanying exhibits indicate, the results were then tabulated.

Despite all of these precautions, however, several deviations from averages of other hospitals were noticeable. Notes to the exhibits attempt to explain some of these deviations, which occurred for the following reasons:

– Inconsistencies in interpretation of the American Hospital Association chart of accounts.
– Variances in organizational structure.
– Absence of certain costs.
– Degree of departmentalization of costs.
– Local conditions.

Other factors which contribute to the differences in charges and costs among hospitals in the study include:

– Extent of services rendered to patients which are uncollectible (charity, discounts, bad debts).
– Percentage of private accommodations.
– Number of beds to the nursing station.
– Age of the hospital plant.
– Percentage of various services – surgical, obstetrics, pediatrics and so forth.
– Volume of outpatient work.
– Extent of other operating income, endowments and so on.
– Scope of personnel benefits.
– Size of the institution.

In addition to helping us compare our cost structure accurately with that of other hospitals in the South, the study illustrated once again what most accountants already know: Many factors must be considered in order to understand adequately comparative cost figures between hospitals. **A thorough understanding of the organization structure of each participating hospital must be achieved if such studies are to be reliable.** ■

Mr. Hottum is assistant administrator of Methodist Hospital, Memphis, Tenn.

EXHIBIT A — SUMMARY OF AVERAGE INCOME AND COSTS PER ADULT PATIENT DAY

For the Six Months Ended June 30, 1959

Hospital	A	B	C	D	E	F	G
Average income per adult patient day (Schedule 1)	$35.09	30.59	33.38	34.52	36.74	28.13	38.05
Percentage of uncollectibles	11.43%	4.53%	12.08%	8.06%	6.38%	9.77%	10.35%
Less — uncollectibles	4.01	1.39	4.03	2.78	2.34	2.75	3.94
Net income per adult patient day	**$31.08**	**29.20**	**29.35**	**31.74**	**34.40**	**25.38**	**34.11**
Average cost per adult patient day:							
Salaries (Schedule 2)	$17.50	15.72	15.14	17.81	19.77	14.91	17.10
Supplies and expense	10.73	10.89	10.96	9.84	11.81	8.59	9.57
Total	28.23	26.61	26.10	27.65	31.58	23.50	26.67
Depreciation*	2.27	1.19	0.94	1.51	1.59	1.35	1.33
Total cost per adult patient day	**$30.50**	**27.80**	**27.04**	**29.16**	**33.17**	**24.85**	**28.00**
Net income (or loss) per adult patient day	**$ 0.58**	**1.40**	**2.31**	**2.58**	**1.23**	**0.53**	**6.11**
Percentage of salaries to total operating costs (excluding depreciation)	62.0%	59.1%	58.0%	64.4%	62.6%	63.4%	64.1%
*Depreciation:							
Buildings	$0.58	0.63		0.53	0.42	0.51	0.50
Fixed equipment	0.86	—		0.33	0.46	0.11	0.83
Movable equipment	0.83	0.56		0.65	0.71	0.73	
Total	**$2.27**	**1.19**	**0.94**	**1.51**	**1.59**	**1.35**	**1.33**

SCHEDULE 1-A — AVERAGE INPATIENT INCOME PER ADULT PATIENT DAY

Six Months Ended June 30, 1959

Hospital	A	B	C	D	E	F	G
Routine service (room and board)	$15.62	13.45	15.67	16.80	14.62	12.19	14.68
Nursery care	0.63	0.55	0.31	1.00	0.65	0.30	0.71
Operating room	2.27	2.31	1.98	3.45	2.90	1.97	2.87
Delivery room	0.37	1.00	0.26	1.19	0.56	0.50	0.35
Anesthesiology	1.70	(1) —	2.02	1.58	2.68	(1) —	1.98
Radiology	3.08	2.70	2.47	1.58	2.26	2.76	2.33
Laboratory	3.20	2.04	3.09	2.65	4.12	3.73	5.32
Blood bank	1.20	1.36	1.18	1.17	2.12	0.91	(17) 0.21
Medical and surgical supplies	0.91	1.43	1.83	(2) —	(2) 0.47	0.35	(10) 3.76
Drugs	4.64	3.96	3.48	4.68	5.07	5.02	4.80
Oxygen	0.64	0.43	0.36	0.24	0.71	(3) —	0.91
Cots — guests	0.17	0.10	0.23	—	0.03	—	0.12
Income from patients' phones	0.33	—	0.27	0.07	0.01	0.01	0.01
Electroencephalograms	0.03	0.17	—	—	—	—	—
Physical therapy	0.19	0.04	0.08	0.11	0.20	0.16	—
O. B. dressings	0.11	—	—	—	0.09	—	—
Emergency room	—	—	—	—	—	—	—
Other	—	1.05	0.15	—	0.25	0.23	—
Total	**$35.09**	**30.59**	**33.38**	**34.52**	**36.74**	**28.13**	**38.05**
Percentage of occupancy	86.61%	90.86%	84.8%	87.1%	90.4%	85.0%	95.0%
Patient days:							
Adult	67,356	71,985	131,141	62,091	46,153	56,705	57,628
Newborn	8,102	9,719	7,755	10,289	6,152	5,113	5,096
Total	**75,458**	**81,704**	**138,896**	**72,380**	**52,305**	**61,818**	**62,724**

NOTES TO ALL SCHEDULES

(1) All anesthesia done by private duty anesthetists.
(2) Medical and surgical supplies included in drugs.
(3) Oxygen included in drugs.
(4) Retail drug store.
(5) All outpatient lab goes to pathologist.
(6) Elevator operators included in housekeeping instead of operation of plant.
(7) Maintenance of personnel included in housekeeping and nursing education.
(8) Has outside food service.
(9) Delivery room included in nursing service.
(10) Solutions included in medical and surgical income.
(11) No nursing school. Students on affiliation paid per diem.
(12) Water furnished free.
(13) Personnel fringe benefits cost departmentalized.
(14) Only personnel fringe benefit cost is F.I.C.A. which is included in administration-other.
(15) Message rate basis for charge on outgoing telephone calls from patients' rooms.
(16) Floor supplies included in nursing service.
(17) No blood bank. Blood secured through foundation.

SCHEDULE 1-B — PERCENTAGE OF OUTPATIENTS TO TOTAL PATIENT INCOME, BY DEPARTMENTS

Six Months Ended June 30, 1959

Hospital	A	B	C	D	E	F	G
Operating room	—	1.95%	1.8%	1.0%	—	1.84%	—
Anesthesiology	—	—	—	6.7	—	—	—
Radiology	28.18%	23.48	16.3	15.2	26.3%	19.63	—
Laboratory	10.99	(5) —	16.0	6.8	0.5	1.90	—
Blood bank	—	—	1.6	19.5	2.53	—	—
Medical and surgical supplies	1.80	0.48	0.4	—	—	—	—
Drugs	(4) 16.10	5.72	22.4	3.2	—	—	—
Oxygen	0.46	—	—	—	—	—	—
Income from patients' phones	—	—	—	—	—	—	—
Electroencephalograms	36.69	—	—	—	—	—	—
Physical therapy	28.38	34.00	34.2	3.0	27.29	—	—
Emergency room	100.00	100.00	100.0	100.0	100.00	100.00	100.00%
Other	—	9.28	39.8	100.0	4.60	25.54	—
Total	**7.65%**	**5.33%**	**6.5%**	**4.8%**	**3.89%**	**5.02%**	**1.27%**

SCHEDULE 2 — AVERAGE COST PER ADULT PATIENT DAY OF SALARIES INCLUDED IN OPERATING EXPENSES

Six Months Ended June 30, 1959

Hospital	A	B	C	D	E	F	G
Administration and general	**$1.65**	**1.51**	**1.54**	**2.31**	**2.11**	**1.49**	**1.46**
Dietary:							
Dietitians	$0.17	(8) 0.11	—	0.10	0.18	—	0.13
Others	0.79	(8) 0.85	—	0.98	0.86	—	0.55
Total dietary	**$0.96**	(8) **0.96**	**0.85**	**1.08**	**1.04**	**0.82**	**0.68**
Household and property:							
Housekeeping	$0.60	(6) 0.99	0.53	0.86	0.85	(7) 0.60	0.55
Laundry and linen service	0.36	0.35	0.25	0.40	0.59	0.41	0.28
Maintenance of personnel	0.16	0.16	0.06	—	0.14	(7) —	0.07
Operation of plant	1.13	(6) 0.72	0.94	0.93	1.08	0.70	0.46
Others	—	—	—	0.01	—	—	—
Total household and property	**$2.25**	**2.22**	**1.16**	**2.20**	**2.66**	**1.71**	**1.36**
Professional care of patients:							
Nursing service	$5.56	5.03	4.23	6.15	6.66	6.06	6.84
Medical and surgical — residents, interns, externs, history writers	0.64	0.51	0.55	0.31	0.55	0.52	1.06
Medical and surgical — C.S.R. R.N.'s	0.05	0.03	0.48	0.05	0.12	{	0.04
Medical and surgical — C.S.R. others	0.32	0.37	0.33	0.22	0.40	{0.21	0.16
Pharmacists	(4) 0.34	0.16	0.28	0.39	0.40	0.24	0.12
Nursing education	0.38	0.40	0.28	(11) 0.26	0.67	(7) 0.66	0.71
Medical records	0.33	0.19	0.30	0.39	0.44	0.26	0.28
Operating room — R.N.'s	0.42	0.35	{0.61	0.62	0.48	{ —	0.62
Operating room — others	0.63	0.42	{	0.51	0.53	{0.90	0.44
Delivery room — R.N.'s	0.28	0.17	{0.55	0.31	0.40	(9) —	0.27
Delivery room — others	0.23	0.20	{	0.37	0.05	(9) —	0.24
Anesthesiology — M.D.'s	0.22	(1) —	{0.63	0.11	—	(1) —	—
Anesthesiology — others	0.58	(1) —	{	0.40	1.01	(1) —	0.28
Recovery room — R.N.'s	—	0.16	{0.13	0.23	—	{0.18	0.23
Recovery room — others	—	0.06	{	0.09	—	{ —	0.15
Inhalation therapists	0.01	—	0.01	0.05	—	—	0.16
Radiology — M.D.'s	1.00	0.46	{1.01	0.31	0.34	0.32	0.47
Radiology — others	0.34	0.40	{	0.26	0.32	0.38	0.28
Pathology — M.D.'s	0.55	(5) 0.17	{1.65	0.30	0.60	0.37	0.40
Pathology — others	0.71	1.00	{	0.78	0.79	0.62	0.81
Physical therapy	0.05	0.03	0.04	0.05	0.08	0.06	—
Electroencephalograms	—	—	—	—	—	—	—
Emergency room — R.N.'s	—	—	—	—	—	—	—
Emergency room — others	—	—	—	—	—	—	—
Others	—	0.92	0.11	0.06	0.12	0.11	0.04
Total professional care of patients	**$12.64**	**11.03**	**10.97**	**12.22**	**13.96**	**10.89**	**13.60**
Total	**$17.50**	**15.72**	**15.14**	**17.81**	**19.77**	**14.91**	**17.10**

NOTES ON SCHEDULE 2

If dietary salaries included the salary of the dietitian who teaches student nurses, reallocation was made of that portion allocable to nursing education.

If housekeeping included the salaries of any maids and porters regularly assigned to any of the specialty departments, such as x-ray, lab, and so forth, reallocation was made.

Nursing service administration included director of nursing service, her assistants and secretaries within the nursing administration office. If any portion of this administration cost was allocable to nursing education or other centers, reclassification was made.

ABOUT PEOPLE

Administrators

Robert P. Lawton, administrator of Danbury Hospital, Danbury, Conn., has been appointed administrator of Grace-New Haven Hospital, New Haven, Conn., working directly under **Dr. Albert W. Snoke,** the executive director. Mr. Lawton succeeds **John T. Law,** who became director of the Hospital for Sick Children, Toronto, Ont. Before his appointment to Danbury Hospital in 1954, Mr. Lawton was assistant administrator of Mary Fletcher Hospital, Burlington, Vt. He is a past president of the Vermont Hospital Association, and a fellow of the American College of Hospital Administrators.

R. P. Lawton

Miriam Curtis, administrator of Syracuse Memorial Hospital, Syracuse, N.Y., since 1941, has announced her retirement. Previously, Miss Curtis was superintendent of Cooley Dickinson Hospital, Northampton, Mass. She is a past president of the New England Hospital Association, a director of Group Hospital Service, Inc. (Blue Cross), and a fellow of the American College of Hospital Administrators.

H. Robert Cathcart has been named vice president of Pennsylvania Hospital, Philadelphia. Mr. Cathcart will continue as administrator of the hospital's Department for the Sick and Injured and will also be in charge of the Institute of Pennsylvania Hospital, Philadelphia. He is secretary-treasurer of the Delaware Valley Hospital Council and secretary-treasurer of the advisory committee of the Careers in Nursing Committee.

James L. Smith has resigned as administrator of New York Medical College-Flower and Fifth Avenue Hospital, New York. Mr. Smith was formerly associated with Memorial Center for Cancer and Allied Diseases, New York.

Emanuel Weisberger has been appointed executive director of Beverly Hills Doctors Hospital, Los Angeles. Mr. Weisberger was superintendent of Cedars of Lebanon Hospital, Los Angeles, for 14 years, president of the California Hospital Association in 1950-51, and president of the Hospital Council of Southern California in 1949-50. He has been a consultant in hospital administration to the California Department of Health and is a member of the A.C.H.A.

Owen P. Hatley has been appointed administrator of Foster Memorial Hospital, Ventura, Calif. Mr. Hatley was assistant administrator of Charles T. Miller Hospital, St. Paul, and previously was director of the hospital and medical facilities section of the Idaho Department of Public Health. He received a master's degree in hospital administration from the University of Minnesota.

William L. Branson, formerly assistant director, inpatient services, Cleveland Metropolitan General Hospital, Cleveland, has been promoted to deputy director. Mr. Branson is a graduate of the Washington University program in hospital administration. The hospital also announced that **David A. Miller,** formerly administrative assistant, has been appointed assistant director for inpatient services. Mr. Miller is a graduate of the University of Chicago's program in hospital administration.

Arthur Feigenbaum, executive director of Jewish Chronic Disease Hospital, Brooklyn, N. Y., has been appointed administrator of Interboro General Hospital, Brooklyn, N. Y.

George H. Cowen Jr., former assistant administrator of Northwest Texas Hospital, Amarillo, has been appointed administrator of Wadley Hospital, Texarkana, Tex., succeeding **David K. Huffman,** who resigned. **James E. Magee** has been appointed administrator of Bucy-Glenn Hospital, soon to be constructed in Linden, Tex. Mr. Magee had been purchasing agent at Wadley Hospital.

Irving Rosenthal has been named assistant administrator and **John H. Drenning** has been named personnel director of Children's Hospital, Philadelphia. Mr. Rosenthal, formerly of the Hospital Council of Western Pennsylvania staff in Pittsburgh, previously was director of Wentworth-Dover City Hospital, Dover, N.H., and assistant director of Lawrence General Hospital, Lawrence, Mass.

Reed L. Clegg has been appointed manager of Veterans Administration Hospital, Iron Mountain, Mich. Mr. Clegg was assistant manager of the V.A. hospital in Salt Lake City.

Dr. E. Dwight Barnett has resigned as administrator of Palo Alto-Stanford Hospital, Palo Alto, Calif. Dr. Barnett went to Palo Alto in February 1958 after serving as director of the School of Administrative Medicine, Columbia University. Previously, he had been administrator of Harper Hospital, Detroit. **Oliver Deehan,** assistant administrator, was named acting director pending appointment of Dr. Barnett's successor.

John K. Miles has been named assistant administrator of Iowa Methodist Hospital, Des Moines. Mr. Miles was formerly assistant director of Vanderbilt University Hospital, Nashville, Tenn., where **D. Andrew Grimes** has been appointed assistant director. Mr. Grimes, administrator of Greene County Memorial Hospital, Waynesburg, Pa., has been succeeded by the assistant administrator, **Eugene L. Strosser.**

John T. Foster has been appointed administrator of Johnson Memorial Hospital, Stafford Springs, Conn., succeeding **Nellie S. Geary, R.N.,** who retired this spring. Mr. Foster is a graduate of the program in hospital administration at Yale University.

J. T. Foster

Roger W. Marquand and **George F. Walls** have moved into new positions in the county hospital system of Cleveland. Mr. Marquand has been appointed County Hospitals administrator after serving as director of Highland View Hospital, Cleveland, for nearly 10 years. His new job is coordinating the operation

(*Continued on Page* 152)

A Modern Management Feature

If he places too much reliance on those management skills in which he excels, an administrator may actually weaken his over-all effectiveness

An Administrator's Best Traits May Be His Worst Enemies

Ray E. Brown

THE skilled administrator has not only a skilled mind but also a strong mind. Exercise causes both. His strength and skill of mind are his greatest assets, but they can at times represent a handicap. Like the athlete who may through repeated use overdevelop certain muscles, which hampers his performance, the administrator may overdevelop certain mental traits because of his repeated exercise of them. Just as the athlete may become muscle-bound because of the nature of his activity, the administrator may develop a sort of mental-boundness in carrying out his work.

The nature of the administrator's work tends to cause him to cultivate consciously, and unconsciously, certain mental traits which can importantly influence his judgment. The fact that these traits are utilized so often by the administrator indicates that they are necessary and valuable to his work. Their value to the administrator lies in his use of them, however, and not in their use of him.

The mental-bound administrator is in a sense the victim of his own excellence, but he still is a victim. Too much can often be more damaging than too little.

It is quite probable that the unwitting overdevelopment and overuse of particular administrative talents is a part of the answer to the puzzling

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Mr. Brown is superintendent of the University of Chicago Clinics. This article is a continuation of a series by Mr. Brown that examines various aspects of the administrative process. Further articles in the series will appear in this journal in succeeding months.

arrested career progress of some administrators. Every field of administration has had numerous and notable examples of highly promising younger administrators who petered out in mid-career. These men demonstrated unusual skills and talents and were definitely effective for a period of time. We are likely to write them off as a "flash in the pan" when they fall back from their earlier pace.

It Is Only Natural for Administrators To Utilize Their Best Traits at the Expense of Their Weakest Traits

This is a very inadequate answer because it doesn't explain what provided the flash and why it burned out before it became a steady flame. A careful study of the careers of these individuals will quite likely show that they did possess, in unusual amount and quality, some of the personal skills and characteristics that bring a premium in administration. Because these were the traits that gave them success, and attracted attention to them in the first place, it is only natural that these traits would be highly utilized.

These administrators would be expected to employ their best traits, even as a substitute for more indicated skills in certain situations. For instance, those with a high level of human relations skills, but short on conceptual skills, could be expected to use their "winning ways" as a substitute for logical justification in implementing an idea. Also, both their superiors and subordinates could be expected to call on their strengths, rather than their weaknesses, when making assignments or seeking their assistance.

The high utilization, and consequent high development, of their best traits would be at the expense of their weakest traits. Not only would the weaker traits suffer by comparison but also by neglect. Thus the disparity would be accumulative.

We are all prone to put our best foot forward and to use most the tool or skill with which we are most adept. The same disparity in development of skills, to some extent, must occur with the average administrator as well as with the gifted. While it is true that certain situations call for extensive use of particular traits and skills, and even certain enterprises call for greater use of some skills, this does not mean that the less used skills must not be strong. While an administrator may be better than the job he has, his weaker skills may not be any less than those required for the level of administrative responsibility he occupies. In general, administrators move upward to jobs where administration is more difficult to practice, when they do move. In most instances they are moved upward because of their best skills whereas their performance will most likely be limited by their weakest skills. This could explain why many administrators do not live up to their apparent abilities and potentialities.

This could also help explain a number of other enigmas in the management selection and development programs that have been tried so extensively in recent years. Much time and effort have been expended in an effort to select men of promise and to hasten their development through special evaluation and training programs. Toward this end great stress has been placed on isolating traits and skills commonly associated with administrative success. Validated tests have been developed for determining the level of those skills and traits in individuals. Their superiors have been urged to identify those characteristics and to coach their proteges in the development of them.

> ***Everyone, however, is about ready to admit that the management development programs aren't much more successful in predicting, or developing, successful performance than the old method of survival of the fittest. The lack of results in the "scientific" programs could be due to the failure to examine the implications of the high scores made in these tests on certain traits, and to think in terms of rounded or balanced abilities. Perhaps a very high score on a few traits is a more adverse predictor than much lower scores on all traits.***

Also, in this connection an average made up of some very high and some very low scores is in no way the same as a fairly even balance between the highest and lowest scores on the various traits being measured. The attempt to "culture" administrators through planned rating and coaching programs could produce the same lack of balanced development. The "rater" and "coacher" is likely to devote attention to those traits and skills his activity uses most often and the budding administrator is likely to seek to press the development of those characteristics that he learns will impress the "rater."

It is highly doubtful that the superior, who after all is a practitioner rather than an informed and objective tutor, will really know all the skills and traits that form the matrix for successful administration. The fact that he, himself, possesses them has little to do with his being able to isolate and understand them. True, if he is a successful administrator he knows how to spot an effective assistant, but this doesn't mean he knows how he does it. The chances are he does it on the average and by the assistant's general performance. This means he doesn't seek specifics

and doesn't have to justify his evaluation precisely in terms of somebody else's criteria.

He usually trains his assistants by letting them roast in the general fire of experience rather than overcooking them in spots. He works on their weaknesses by correcting their shortcomings instead of exalting their strengths to prove he is an able teacher.

Whatever else the administrator is, he must be well balanced in judgment and in actions. Administration calls on the whole of a man's genius and not alone on certain particular intellectual skills or traits. It is hard for the administrator to develop himself as a whole, however, because his work calls for him to use some abilities much more often than others. This not only leads to imbalance but at times leads to unwitting misuse of some of those abilities. Here are some of these abilities that I have observed which seem to influence importantly the administrator's judgment.

The ability to generalize is one of the skills most needed and most used by the administrator. This is true for a number of reasons. There are times when he simply doesn't have access to all the facts and has no way of obtaining them. He must take the incomplete and inadequate information that is available and contrive a picture from it. In some instances he chooses to forego portions of the information because its value is marginal in relationship to the cost of obtaining it. In other instances there just isn't sufficient time to marshal all the needed information.

In any event, whatever information the administrator does have is historical and must be projected in light of the situation that currently confronts him. The information provides him with a background but he must still call on his imagination for the picture he paints on the background. Trying to view the future through a rearview mirror often forces the administrator to make a little bit of information go a long way.

The enforced habit of working with partial information tends to develop highly the conceptual skills of the administrator so that he can visualize the whole by seeing a few of its parts. This is a very essential skill in administration and perhaps the most important of all the skills required of the administrator. Its use can be intoxicating to the administrator's judgment, however, and can get out of hand. If used indiscriminately it can lull the administrator into the practice of sweeping generalizations that are spurious and unfounded.

The temptations to overuse this ability are strong and insidious. The pressure of time forces the administrator to use a mental hack saw that cuts a host of lesser factors down to a few that he considers critical and that project the picture for him. Also, the diversity of the facts forces him to reduce the lot down to a size his mind can manage. The usual scarcity of significant information causes him to hoard what he gets and re-use the same picture in what he considers similar situations. He hangs onto the past conceptions in order to permit perceptual short-cuts.

Administrators See What a Person Does Rather Than What He Is

Thus the more his experience, the more filled his mind with preconceptions that he is prone to substitute for new considerations. The use of warmed-over generalizations formed from past experiences makes life more comfortable as well as simpler. The administrator doesn't have to face up to changing his views and his images.

The tendency to overgeneralize is hazardous because of the unique nature of the judgment process. It seems to be much more concerned with similarities than differences. One could describe it as a search for regularities. The process appears to have a deep affinity for the familiar and to feel much more at home behind the solid fortifications of precedent. Good judgment, however, must be alert for the unique. It must also respect the odd.

The fact that an apparently similar situation reoccurs is some evidence that something new has been added to upset the previous solution. The setting may be repeated many times within the same organization, or in the same administrator's experience, but it is highly doubtful that all the facts are ever completely duplicated. One can use the same frame for a variety of pictures. Also, one may get an accurate idea of the picture in a jig-saw puzzle even if a number of the pieces are missing, but the picture may be greatly distorted if one attempts to substitute pieces from a different puzzle.

A form of generalization quite often used by administrators is the stereotyping of individuals. The tendency may be stronger in connection with individuals than with situations, because administrators deal with people and are trained to see situations in terms of people. The administrator is always looking for the human coefficient of problems and usually will attempt to personify situations by projecting persons into them. He has learned that things are caused and insists that the personal responsibility for things be singled out.

> ***Where the usual person is likely to depersonify entire organizations by giving them a faceless entity such as "the government," "the law," "the church," and so on, the administrator will insist on pinning faces on the entities within the organization. This may not always be as accurate as the faceless approach and may at times be quite misleading. Casey, the cop, may more often personify "the law" when he is in the uniform, than he does Casey, the guy with a wife and kids, when he is out of uniform.*** (*Cont. on Next Page*)

Although the administrator tends to look for the person in the situation, he does not have the same tendency to look for the man in the person. Or better stated, he is likely to see what the person does rather than what he is. This causes him to label individuals in terms of organizational performance, such as able, dependable, stable, cooperative, restrained, and so forth, or the reverse of these.

Such labels are of course necessary if the administrator is going to know whom he is depending upon and the degree to which he can depend upon whom. At the higher administrative levels the administrator leads a sheltered life, from the standpoint of most of the actual operations, and must depend upon others for both information and advice. This means that he has to decide what to believe as well as what to do. This doesn't mean that he distrusts those around him, but that he must do a job of distilling.

If he can label the source he knows the per cent proof without testing the contents each time. The same problem or incident can come to him in quite different wrappers, depending upon the personality of the individuals doing the wrapping. In one sense administration is a matter of making allowances. For some individuals, such as the overanxious or the perfectionist, the administrator learns to discount. For other individuals, such as the restrained or the easygoing, the administrator learns to add.

By classifying people the administrator can save himself time and actually increase the validity of the information provided him by honest people. By hanging images onto people he simplifies their personalities into manageable totals. It sounds like double-talk, but the administrator catalogs people by their ambiguities in order to ignore their differences. The practice is a valuable one to the administrator if he controls it. His life is much simpler if he can deal with stereotypes rather than ambiguous characters.

The Greatest Hazard in Classifying People Is the Rigidity of First Impressions

Tucking people into mental pigeonholes is a hazardous occupation, however. It is easy to get them into the wrong hole and it is hard to keep them in the right hole. People are difficult to classify properly. They won't stay put. Without attempting to examine the wonderful complexities of human behavior, which horribly complicate the task of neatly classifying individuals, there are some practical difficulties that the administrator must keep in mind. If these are not considered he can easily misjudge individuals and also misuse an otherwise valuable skill in administration.

The administrator seldom gets a full view of individuals in the organization. He sees only their work side. This may be a very cloudy view of that side. Some of the time he sees them when they have problems and gets a troubled view. Often, he gets his image second hand and looks more for confirming evidence than different evidence.

We are likely to let a single incident fix our image of an individual. Such a single incident may be entirely fortuitous. It can leave a favorable impression because it was a pleasant circumstance or an easy problem to solve. On the other hand, it can leave an unfavorable impression because it was in connection with an unpleasant circumstance or an extremely difficult problem, all beyond the control of the individual.

The greatest hazard, however, is the rigidity of images. The first impression is a persistent one. We keep seeing people as we first saw them. This denies the fact that individuals can be changed, and do change. The administrator does not come to work with the same people each day. They may have the same names and the same faces, but they are not the same persons they were yesterday. The capacity to adapt is a strong one and this capacity survives with great strength throughout all an individual's life. The administrator must keep his impressions up to date if he hopes to use them profitably and also fairly.

The pressure to simplify encourages another tendency which can importantly short-cut the administrator's judgment. This is the tendency to classify everything as either black or white—as good or bad. The urge to use the black-or-white technic in sizing up situations and individuals is a strong one and can develop from several directions. The deficit of time which always plagues the administrator doubtlessly causes him to seek and give quick answers. The housekeeper instinct to keep the desk clean leads some administrators to dispose of the file by quick off-the-cuff decisions. In other instances emotional factors can cause the administrator to pick sides and thus eliminate the bother of looking at the other side. The proved advantage of decisiveness in administration may also be a strong force. The urge and ability to simplify problems do, of course, represent important assets of the administrator if they are tempered with the knowledge of the dangers involved. These dangers are several.

Such a tendency denies the fact that it is the administrator's task to discriminate between acceptable alternatives more often than between a good or bad solution. The choice is seldom between a right or wrong way but rather between greater and lesser values to be derived from the different means available. Also, the problems requiring the solution are rarely ever black or white in nature but are usually of varying shades of gray. At least if the administrator is fulfilling his proper role only the gray problems

will reach his desk. The clear-cut ones will be settled down the line where the facts are more abundant and better understood. At best, administration at each level is isolated from the flow of information generally known at a lower level.

Those problems that properly survive ascent up the diagnostic ladder are most likely to be multifactoral and multisided. The latter is especially true since the ascent exposes the problem to the views of those at each administrative level and gathers partisans as it moves upward.

A quick answer to a problem can sometimes be self-defeating even if it is the best answer. Problems which are properly screened to the top level of the organization usually carry with them the troubled ponderings of those involved along the line of ascent. This means that questions permitted to reach the top level must be treated with respect, no matter how simple they may appear to the administrator.

A cavalier treatment of a problem that appeared difficult and tortuous to the other person will make the administrator look smart — but smart like an aleck. It will also make the other person look foolish to himself. None of us have any love for those who pin the donkey's tail on us. If the solution represents a choice between conflicting views of two individuals, the loser is automatically justified in believing that his side did not get a full hearing. This can damage the organization's opinion of the administrator's judgment because people always associate fullness with fairness. It can also cause the administrator's judgment to be labeled as naive.

> ***No matter how simple the problem, there are times when the administrator must talk it through with the individual involved. This not only demonstrates respect and concern on the part of the administrator, but reveals both the facts and the feelings that produced the problem.***

Facts are a great deal like darning yarn in their proclivity to become tangled, and their ends are even more difficult to find. The feelings often get entwined with the facts and represent more of a problem than do the facts. When a person is disturbed fancy can be easily confused with fact, and the two must be carefully unraveled before a solution will be fully accepted by the individual concerned.

Many People With Problems Are Not Seeking Solutions As Much As Reassurance and a Sense of Identity

Oftentimes it is not so much a question of talking through a problem as it is of listening through an individual. The problem the individual brings to the administrator may be of minor consequence or it may even be manufactured. But whether real or contrived, it is really intended as a calling card and the solution is not important. The individual is seeking assurance and identity instead of solutions. The answer he seeks cannot be stated in direct terms by the administrator but must be stated indirectly in terms of the time and interest he is willing to devote to the individual.

Such need for reassurance is a universal of all individuals and varies only in degree. The administrator has the same need and can recognize it in his own behavior in those instances in which he wanders wide of the subject in discussions with his colleagues. Normal individuals learn to keep the need for reassurance under control and thus avoid too much dependency. The administrator must recognize this need, however, and on occasion must consciously listen the individual through even though he knows the answer he is going to give almost as soon as the conversation has started. This is admittedly a very difficult assignment because answers are almost impossible to suppress and it is a strong human characteristic, whether in the kindergarten or the administrator's office, to want to be the first to raise the hand.

The need and urge to simplify problems and reach decisions should not cause the administrator to forget that judgment is a combination of heart and head. There is always a danger that he will permit the decision to become the only interest. Decisions affect feelings for better or for worse. One important thing about feelings is their need for expression. One of the surest ways of expending feelings is to verbalize them. One of the safest places to do this should be the administrator's office.

> ***In the same company with the black-or-white outlook is another categorical sweep. This can be described as the all-or-none complex — to attempt only perfect solutions instead of the accomplishable. The restless pursuit of excellence which marks the effective administrator is likely to cause him to overlook the fact that sometimes a half a loaf is really better than none. The unconditional surrender sort of administration can lead to either of two extremes.***

On the one extreme it can mean that an improvement is never undertaken because the ideal solution isn't currently possible. Necessary changes will seldom be started because the opportunity for perfect solutions rarely comes along. Ultimately, it can lead to a form of alibi administration in which the administrator points to excuses rather than results. Major changes are always difficult to accomplish. Even the bravest and most energetic of administrators is sometimes tempted to rationalize his distaste for facing up to these difficulties by holding out for the perfect solution.

(*Continued on Next Page*)

This sort of thinking can become chronic and seriously impair the administrator's effectiveness. If he develops a habit of searching for obstacles he will be sure to find them. Most problems are problems because they have run into obstacles. If the administrator develops a negative attitude he can pick any idea apart in terms of the difficulties it presents. The administrator who greets every idea for improvement with a carefully documented list of obstacles soon discourages even the most enthusiastic individuals in the organization.

One of the greatest problems of the administrator is the inertia, and even antagonism to change, that besets all organizations. His task is to kindle enthusiasm for change and new ideas. A wet blanket can smother the brightest of ideas but it is not generally considered very useful in kindling one.

Even where the administrator sincerely desires change he must guard against the stifling effect that can be a by-product of the search for perfection. If he feels compelled always to find the very best answer he is not likely to be an efficient problem solver. Because the very best cannot be known until every fact is known, he will never know when to stop looking. This means that he will take flight into a wilderness of detail that has increasingly diminishing meaning to the problem. As necessary as detail is, it represents a burden to judgment in that each detail must be examined as to its meaning and its proper weight. Too much dependence on detail can also result in a loss of confidence by the administrator in his own judgment. He may fear that something has been left out or become uncertain as to the meaning of the detail available to him. This may cause him to seek support through a study, a special committee, or an outside consultant. Each of these is valuable as an adjunct to the administrator's judgment but not as a substitute for it.

The administrator must recognize that there is a difference between what is ideal and what is real and that he seldom has either the time or resources to pursue the ideal. Ordinarily, he is wise to stop his search for alternatives when he finds a workable one. He can only do what he can do but he must get about the business of doing that! The fact that he must stop short of perfection is no excuse for doing nothing.

The failure to recognize that administration is the art of the feasible may lead to the other extreme in which too much is undertaken too quickly. It may mean that the action that is undertaken is too radical and the organization is subjected to turmoil and perhaps violent upheaval. It may mean that the administrator has overreached the financial or physical resources of the enterprise, or that he has overestimated the market or need for its products or services. It may also mean that he has overfigured the competency or adequacy of the people in the organization.

Administrators Must Change the Whys Before Changing the Ways

In instances the changes attempted may be ultimately correct but presently not accomplishable. Such moves ignore the necessity for administrative timing. The successful administrator must at times tolerate conditions of inefficiency rather than court failure by attempting to clear all the hurdles with one big jump. This means that among his repertory of virtues the effective administrator must tuck a high frustration level. So far as he is dealing with people, it also means that he needs more than ordinary patience and tolerance. This does not mean toleration of misdeeds and misperformance. It means that the administrator should know his people, give due regard to their imperfections, and attempt to work within their limitations. He must work toward changing them because that is the purpose of administration. This must be done, however, with the realization that there is a reason why things are as they are. He must change the whys before he changes the ways.

The administrator needs to determine his goals and evaluate the opposition to them. He can thus accept, and even select, lesser results as progress toward larger goals. This permits him to maintain constant pressure toward the desired ends without allowing the pressure to explode into an open break. It also allows him, when necessary, to accept, and attempt, alternatives.

Somewhere between the extremes of inertia and abortive change the effective administrator finds the path of consistent progress. By proceeding along that path, step by step, he can ultimately achieve his long-range plans and at the same time obtain the personal stimulation, so necessary to his own morale, that comes from immediate accomplishments. He should not fret too much about taking a detour if it will take him to the same destination. He must of course be sure it is a detour and not the wrong road. This can be done if he differentiates between the idea and its application. A compromise on the idea will ruin it but a compromise on its application may even improve it. A good idea can often be applied in a variety of ways. The administrator should remember that apparently ideal solutions are really only estimates and are subject to the errors inherent in predicting results that are dependent upon human behavior. In this sense ideal solutions are only proximates and never absolutes. ■

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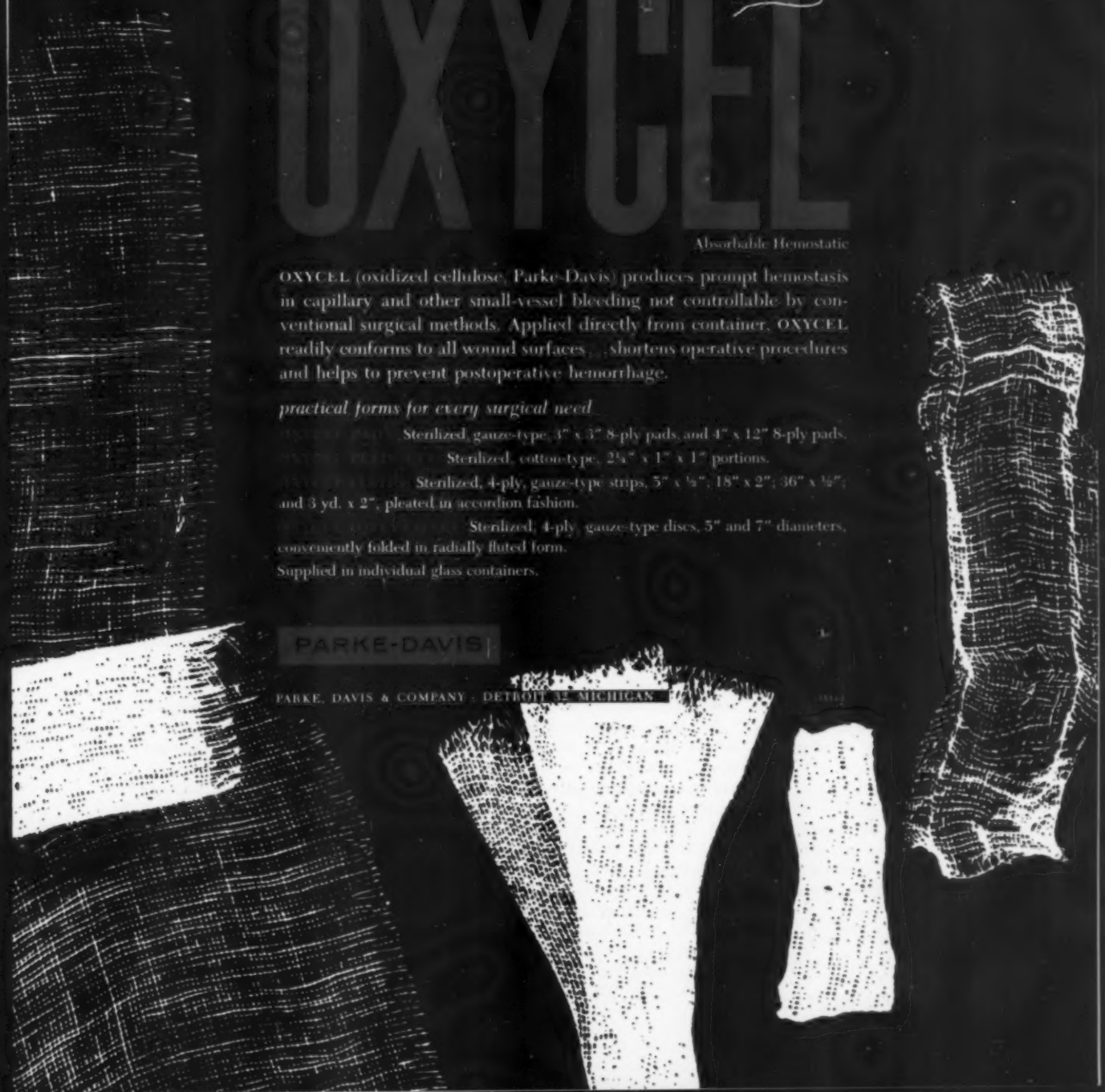

Who Says Surgery Is 'Uncomplicated'?

This report on the spontaneous rupture of the spleen presents the case for proper surgical training of every physician who is allowed to perform surgical procedures

Frank H. Ridgley, M.D.

EXPERIENCED surgeons realize it is safe to call any surgical procedure "simple and uncomplicated" only after it is over and neither complexities nor complications have arisen. It is not safe to assume that any surgery, however simple it may appear at the outset, cannot develop unexpected hazards with which only the fully trained surgeon can deal.

The American College of Surgeons continues its fight against any surgery performed by inadequately trained surgeons, and the College is criticized only by the inexperienced physician in the remaining communities where the inadequately trained or apprentice-type of surgeon is allowed to climb a ladder of surgical privileges.

Our recent experience with a near-fatal situation arising from an unrecognized spontaneous rupture of a spleen might have exacted the price of a human life to prove that graded levels of surgical privileges are hazards that cannot be eliminated in advance except by requiring complete surgical training of each operator who assumes charge of an operation.

Every surgeon can admit to occasions when he has opened an abdomen for anticipated appendicitis and has found an embarrassing situation such as a perforated ulcer, gangrenous gall bladder, neoplasm or some other problem that had evaded preoperative diagnosis. The problem that results then is whether the operator is capable of handling the unexpected surgery that now becomes necessary.

A modified version of this paper also appears in the Bulletin of the American College of Surgeons, July-August 1960.

Dr. Ridgley is chief of surgery of Chester County Hospital, West Chester, Pa.

Training Protects Patient

In the hospital that had a formal residency program there would be a supervising resident or staff member in attendance. In the hospital that does not have such a program, the surgeon is on his own. Minutes can make a critical difference even in a technologically well equipped and well staffed hospital, with its professional anesthesiologist, its radiologists, its full blood bank, and its complete pathological laboratory – including radioactive blood volume studies. Under these emergency circumstances, the breadth of the training of the operating surgeon, in technic as well as diagnosis, is the only protection the patient has until the ancillary services of the hospital and consulting staff are made available.

The case of a spontaneous rupture of the spleen in infectious mononucleosis is a classic example of the unexpected catastrophies in general surgical practice.

A single white female, age 20, was admitted to the hospital with left lower quadrant pain that had its onset suddenly on the fourteenth day of her regular menstrual cycle. She had been in her normal state of good health except for a mild upper respiratory infection treated by her family physician two weeks prior to the chief complaint, and which had left her weak and easily fatigued. The persistence of the localized pain for 24 hours and the lowered red cell count and hemaglobin led to a decision to operate for a left ovarian follicle or ruptured cyst that was bleeding excessively. There was no history of trauma, ovarian cysts, mittelschmerz or a bleeding tendency in any area.

At surgery a briskly bleeding ruptured follicle was found on the left ovary but the large amount of intraperitoneal blood led to the exploration that revealed the subcapsular rupture of the spleen. The patient was now in a serious degree of shock. The splenic pedicle was compressed about the tail of the pancreas until the blood pressure was reestablished. This was accomplished successfully by use of dextran, autotransfusion, and ultimately bank blood. It was then possible to extend the incision and remove the spleen.

An adequately trained surgeon can handle such an emergency in any accredited hospital. No hospital credentials committee can classify surgeons according to those allowed to do simple surgery and those who can take care of complications. The lay public is learning to demand full accreditation of hospitals. The illustrative incident presented here indicates the integral part of hospital care that is required by the American College of Surgeons – a fully trained surgeon. ■

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Itinerant Surgery Is Dangerous for Patient and Hurts the Hospital

By Robert S. Myers, M.D.

ITINERANT surgery still flourishes in the rural areas of the country. Although it is altered slightly in character, it has not changed for the better.

Dr. Robert S. Myers

Itinerant surgery got its start in the early 1900's when surgery became safe and popular and when most of the prominent surgeons were concentrated in the large medical centers. Patients could either journey to the city for their surgery, or the surgeon could go to the patients. Before long, and for a variety of reasons, none of which were valid, many big-name surgeons traveled a regular circuit into the small towns where they would operate upon a number of patients, none of whom they had seen previously and few of whom they would ever see again. Preoperative workup and postoperative care were left to the general practitioner who scheduled patients for the visiting surgeon.

Most of the early itinerant surgeons were general surgeons, since specialization was relatively infrequent at that time. But with the advent of residency programs, more and more young, well trained general surgeons located in the smaller communities, and over the years this reduced considerably the traffic on the itinerant surgery circuit as far as general surgery was concerned. Although the practice is less frequent, it still continues. The slack has been taken up of late by those who have been trained in the various surgical specialties and who now repeat the circuit pioneered by the general surgeons.

Interestingly enough, the arguments advanced to justify itinerant surgery have not changed over the years. One of these is that itinerant surgery by a fully qualified surgeon ensures better care of the patient than surgery done by one with lesser qualifications. A second reason offered by itinerant surgeons is that someone else will do the work if they do not.

A third and recent argument in favor of itinerant surgery has arisen as a result of the great increase in the number of community hospitals throughout the country. It is contended that itinerant surgery in community hospitals lowers the cost of surgical care to the patient and enables these hospitals to increase their occupancy.

All these arguments ignore the fact that itinerant surgery is inimical to the welfare and safety of the surgical patient. Modern surgery is not a mere mechanical procedure; it is the total care of the surgical patient, of which the preoperative management and the postoperative therapy are the most important parts. These must be the direct responsibility of the operating surgeon who is expert in these fields. Moreover, other essentials of adequate surgical care are rarely available to the itinerant surgeon. These include a competent operating room team and nurses, all of whom should be experienced in the practices of the operating surgeon. And finally, itinerant surgery discourages the development of good surgery in community hospitals, for qualified surgeons cannot survive where itinerant surgeons control the surgery.

What is itinerant surgery? The best definition is that of the Board of Regents of the American College of Surgeons which con-

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High Grade Surgical Instruments Must Be Given High Grade Care

By Frances Ginsberg, R.N.

GOOD quality surgical instruments should be treated like the precious things they are. They should be used only for the purposes for which they were designed and they should be properly cleaned, sterilized and stored.

Frances Ginsberg

When I see an Allis clamp used for a towel clip, a Kelley clamp used to occlude suction tubing, or a delicate scissors used to cut wire or heavy suture material, I am angered and annoyed. My attitude toward such misuse of quality surgical instruments is probably attributable to early training to respect things of value coupled with my training as an operating room nurse and my current work as a consultant.

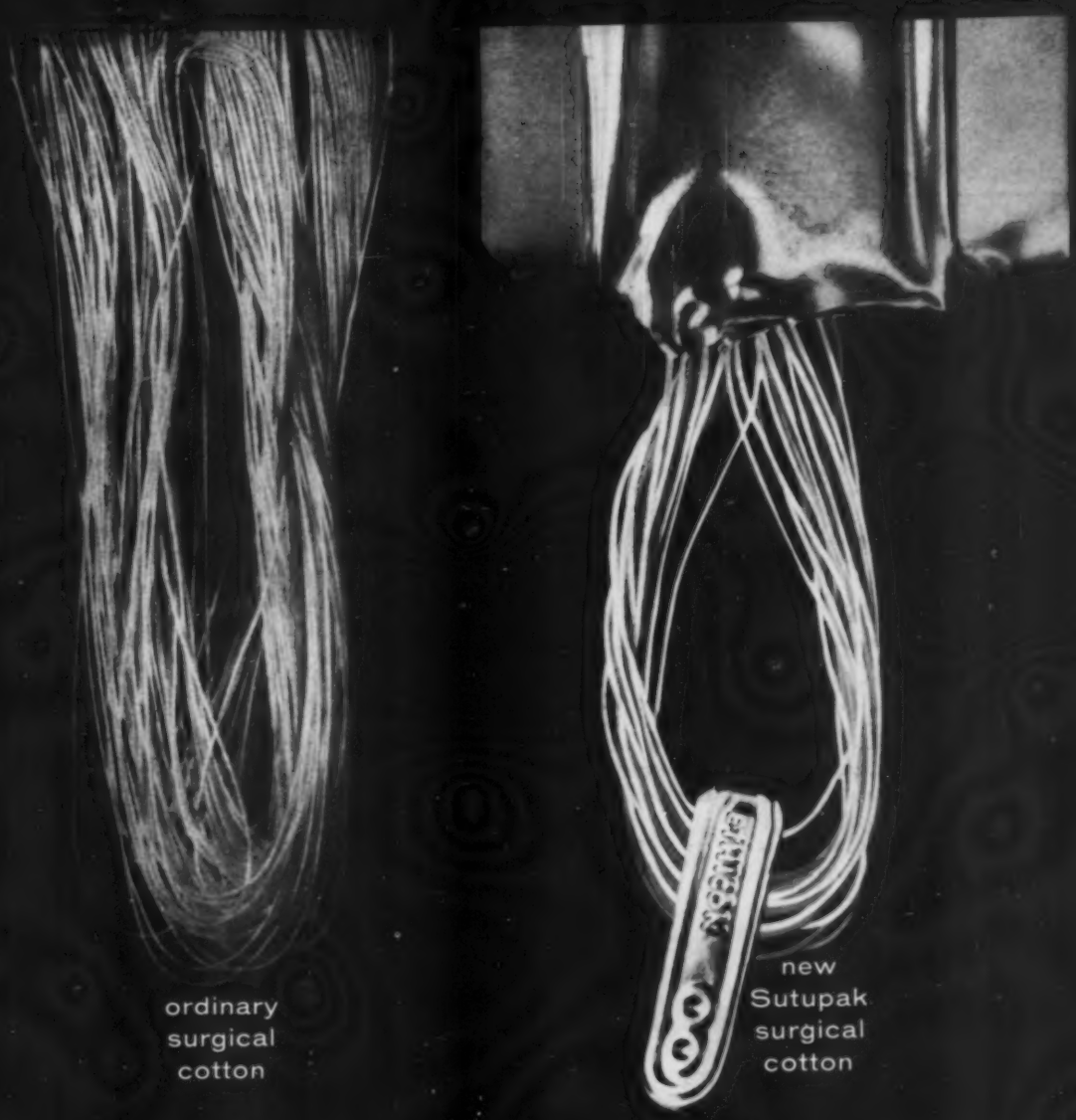
Proper care of surgical instruments is the responsibility of the operating room supervisor and the duty of every one of her nurses. How surgeons choose to use these instruments is often dependent upon how the nurses encourage proper use and discourage improper use. How the nurses themselves use them is entirely dependent upon their training, the respect they have for the instruments, and their awareness of the operational and monetary value of the instruments entrusted to them.

In addition to overt misuse of instruments, they are too often exposed to destruction because of either lack of understanding or laziness. It is obvious that any instrument with moving parts is under unnecessary tension, even when closed on the first ratchet. Quality instruments are commonly destroyed by repeated hand washings in which they are handled and banged together in a sink, and then carelessly thrown into the autoclave. Those who use pressure-washer-sterilizers should also recognize the importance of keeping the instruments open during this procedure. It has been shown that at high temperatures both in an autoclave and a pressure-washer-sterilizer a closed instrument may quickly develop a brittleness within the box lock, which may result in breakage during use.

I have referred to "quality" instruments because only high quality instruments should be purchased and used. If the same disregard of use and treatment is given to inferior instruments, they will wear out more quickly, they will have to be replaced at additional expense, and any funds saved on the original purchase will be quickly dissipated.

It is as important for the welfare of the patient to provide good surgical instruments in reliable condition as it is to assure proper asepsis or provide other equipment and safeguards. ■

Miss Ginsberg is a consultant on operating room nursing and hospital aseptic technics and a member of the Bingham Associates Program at Boston's New England Center Hospital.



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Controls on Narcotics Should Keep Them From Getting Out of Hand

Grover Bowles Jr.

ALL hospitals have narcotics problems at one time or another. Fortunately, most of these are minor problems and only on rare occasion do we hear of a hospital with a serious narcotics problem. This is because administrators, pharmacists and nurses know and appreciate the hazards involved in the handling of these potent agents. They also have a healthy respect for the federal and state laws dealing with narcotics.

No Class Specified

Unfortunately, the federal Harrison Narcotic Act does not provide a specific registration class for hospitals. Hospitals are ordinarily required to be registered in Class 4, which covers the administration of narcotics to patients in the hospital and Class 5, which governs the preparation of and dealing in exempt narcotic preparations. Hospitals must also be registered in Class 3 if narcotics are dispensed to outpatients and in Class 6 if narcotics are required for animal or laboratory use.

Separate inventories and accounting records must be maintained for each class and no trading between inventories is permissible. However, all narcotics may be stored in the same vault or safe.

Here are some of the questions about narcotics that occur from time to time in most hospitals.

1. Who in the hospital is actually responsible for narcotic control?

The administrative head of the hospital is responsible for the proper handling of narcotics in the hospital. He may, and usually does, delegate authority to the chief pharmacist to sign order forms and to receive and dispense narcotics. He may also hold the pharmacy responsible for maintaining proper accounting records for narcotics purchased, received, dispensed and administered. Usually, the nursing service will share in the responsibility for the proper use and control of narcotic drugs where patients are concerned.

2. How should we account for accidentally crushed tablets, broken narcotic ampules, contaminated narcotic solutions, doses of narcotic drugs refused by the patient, and other small shortages that occur at the nursing station?

All damaged or contaminated narcotic preparations should be returned to the pharmacy with a note identifying the preparation, giving the date, reason for return, and the nursing personnel involved. When a dose of a narcotic is refused by the patient or canceled by the physician after it has been prepared, it should be emptied into the sink. This should always be done in the presence of witnesses.

Report Accounts Losses

The use of the narcotic loss report simplifies the accounting for small discrepancies, accidental destruction of a tablet or ampule, for prepared dosages refused by the patient or canceled by the physician, and other minor losses. The narcotic loss report may be an inexpensive mimeographed form giving the patient's name, room number, time, date and narcotic involved. Space should be provided to record how the loss occurred and the report should be signed by the nurse responsible and a nurse witness. The completed form is attached to the dosage administration sheet. In some hospitals, this report is prepared in duplicate with a copy going to the nursing office for information purposes.

When repeated shortages occur or the loss amounts to several doses, the person responsible for narcotic control in the hospital should make an investigation, reporting his findings to the director of nursing service and the administrator. A statement should be prepared, giving the kinds and quantities of narcotics lost or destroyed and the circumstances involved. This signed statement is sent to the narcotic district supervisor and a copy retained with the other narcotic records in the hospital.

3. Are standing orders permissible?

Standing orders, such as those given routinely by the physician for preoperative medication, are not permissible. Individual orders must be written and signed for each patient. P.R.N. orders for narcotics are allowed but should be renewed after 72 hours, regardless of the situation.

(*Continued on Page* 100)

With this issue we begin a monthly column by our consulting editor for pharmacy services, Grover C. Bowles Jr., covering various aspects of modern pharmacy management. Mr. Bowles is director of pharmacy service at Baptist Memorial Hospital, Memphis, Tenn. An active member of the American Society of Hospital Pharmacists, he has been chairman of its committee on program and public relations. He has also served as a member of the society's committee on pharmacy and pharmaceuticals and as its representative on the joint committee of the A.S.H.P., the American Pharmaceutical Association, American Hospital Association, and Catholic Hospital Association.

(*Continued From Page* 98)

Most hospitals limit the use of P.R.N. orders for narcotics to 48 hours under their automatic stop-order policy.

4. Are prescriptions required for hospital patients?

So long as an order for the narcotic appears on the doctor's order sheet, no prescription is required. Narcotics kept at the nursing station are accounted for on the narcotic administration record. The registry number of the physician prescribing the narcotic is not required on the hospital record. However, full name or initials must appear on the doctor's order sheet.

5. May narcotics be administered on the verbal or telephone order of a physician?

When absolutely necessary, narcotic drugs may be administered to patients on the telephone or verbal order of the physician. The nurse should make a notation on the doctor's order sheet stating that it is a "telephone order" or an "emergency order" and sign the doctor's name and her initials. The written order must be signed by the doctor within 24 hours.

6. How should narcotics be stored?

The Treasury Department requires that narcotic drugs and preparations be properly safeguarded and securely kept. Certainly, narcotics should be kept in a secure place. Generally, most hospitals provide a locked cabinet for the daily working stock of narcotics and a vault or safe for the reserve stock. If a safe is used, it should meet the Underwriters Laboratory requirements for an X-60 rating. Such safes are designed to offer protection against attack by tools or explosives for a period of one hour. Small safes that can be moved or carried away should be anchored to the floor.

7. After what length of time can narcotic records be destroyed?

According to federal law, all narcotic prescriptions, dosage administration records, order forms, and other papers pertaining to narcotics, must be on file for at least two years. However, some states require that narcotic records be on file for a longer period of time and for this reason, it would be well to check the state law. ■

Itinerant Surgery Is Dangerous for Patient and Hurts Hospital

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demns this practice: "Itinerant surgery is any surgical operation performed, except one upon a patient whose chances of recovery would be prejudiced by movement to another hospital, in which, because of the distance from the patient, the operating surgeon must delegate the exacting responsibility for postoperative care to another who by training and experience is not fully qualified to undertake it."

This definition excludes surgical care which cannot be delayed, without hazard to the patient, other necessary operations upon patients who cannot safely be moved to a hospital in which the operating surgeon is in regular attendance, and operations requiring special skills, following which the postoperative care is left to another surgeon who is fully qualified to undertake it.

However, these exclusions are relatively infrequent. They do not cover the majority of patients subjected to itinerant surgery in this country. ■

How Patients Feel About Hospitalization

Bernard Seidenberg, M. Herbert Fineberg, M.D., Richard Christie, Ph.D., and Samuel B. Kutash, Ph.D.

AT THE suggestion of the manager of the East Orange V.A. Hospital, a research plan was formulated at that hospital to study the attitudes of patients toward various aspects of the hospitalization experience. A pilot study was then undertaken to test the adequacy of the design and of the interview schedule used to elicit the requisite information before the larger study was begun.

Controlled by Classification

For a period of three weeks, all patients entering the hospital, other than those with a psychiatric diagnosis, were assigned to one of three classifications by the medical member of the research team: chronic severe (C.S.), chronic minor (C.M.), and acute minor (A.M.). This procedure was used to control, for seriousness and duration of illness, factors that were considered to be of possible importance in the etiology of and change in attitudes toward hospitalization. The category "acute severe" was not used in this study because of the dearth of such patients.

Each patient selected was interviewed within three days of admission by psychology trainees, provided it did not interfere with medical treatment and his health permitted. Two weeks later, the patients were reinterviewed, a slightly revised interview schedule being used at this time. A total of 29 patients was interviewed initially, 17 being reinterviewed after two weeks.

In terms of age, race, religion, educational level, and occupational level the sample of patients studied differed in no known way from the rest of the patient population of the hospital. Admitting diagnoses varied widely, reflecting the fact that this hospital is a general treatment center. Here, too, there is no reason to suspect that this sample differed in any meaningful way from the rest of the patient population at the hospital.

The first part of the interview* was designed to disclose patient attitudes toward the hospital and its services, and specific attitudes toward the staff. Recognizing that critical attitudes might not be easily elicited, every effort was made to establish a critical point of view in the patients by means of a specially worded introductory statement.

A sequence of questions designed to ascertain the patient's feelings toward his experiences included the following: "How are things going?" "Are these things not going so well?" "Are there things you think might go wrong?" In each case, 75 to 90 per cent of the patients gave responses which were coded as "highly favorable." Similarly, in the case of more specific questions such as "How have the members of the staff been acting toward you?" and "Do you feel that the doctors and the rest of the staff have done everything possible for you?" patient response was again highly favorable.

Another portion of the interview concerned communication of medical information. Responses to the first question, "What is wrong with you?" indicated that the majority of patients could either name their illness or, at least, could describe their symptoms accurately. While there was a slight tendency for this knowledge to increase after two weeks, there seemed to be no relationship to illness classification or chronicity of the condition.

When asked what information the physicians had given them, most patients reported a relative dearth of information both after three days and after two weeks. While this might lead one to suspect a hunger for information on the part of the patient, this was hardly the case. More than 70 per cent of the patients responded affirmatively to the question, "Do you feel you get enough information from the physician about your condition?" Futhermore, approximately 65 per cent of the patients replied negatively when asked, "Is there anything else you want to know about your condition?"

Few Mention Nurses

Another interesting finding emerged when patients were asked with whom they had discussed their illness. More than 44 per cent of the responses named physicians, while other patients and the patient's family constitute 25 per cent of the responses.

Only five, or 7 per cent, of the responses mentioned nurses. This finding is of great interest and suggests as a possible explanation a change in the role of nurses *vis-a-vis* patients or perhaps the fact that traditionally nurses are trained not to convey diagnostic information to patients.

In summary, our findings were that the attitudes of patients toward the hospital and the staff are quite favorable. Negative and qualified favorable responses which do appear are almost always associated with the patients' feelings concerning their own physical condition or the extensive paperwork required in any hospital setting, or else they seem to be a result of the relatively short period between admission and interview which did not permit all necessary tests and explanations to be given. In no case does any clear-cut criticism of personnel and services, other than administrative, emerge.

With respect to questions concerning knowledge of illness and communication of medical information, in-

(*Continued on Page* 105)

Mr. Seidenberg is social psychology trainee; Dr. Fineberg is chief; Dr. Christie is consultant in social psychology, and Dr. Kutash is chief of the psychology service at V.A. Hospital, East Orange, N.J.

*Copies of the interview schedule and the tabulations may be obtained from the psychology service, V.A. Hospital, East Orange, N. J.

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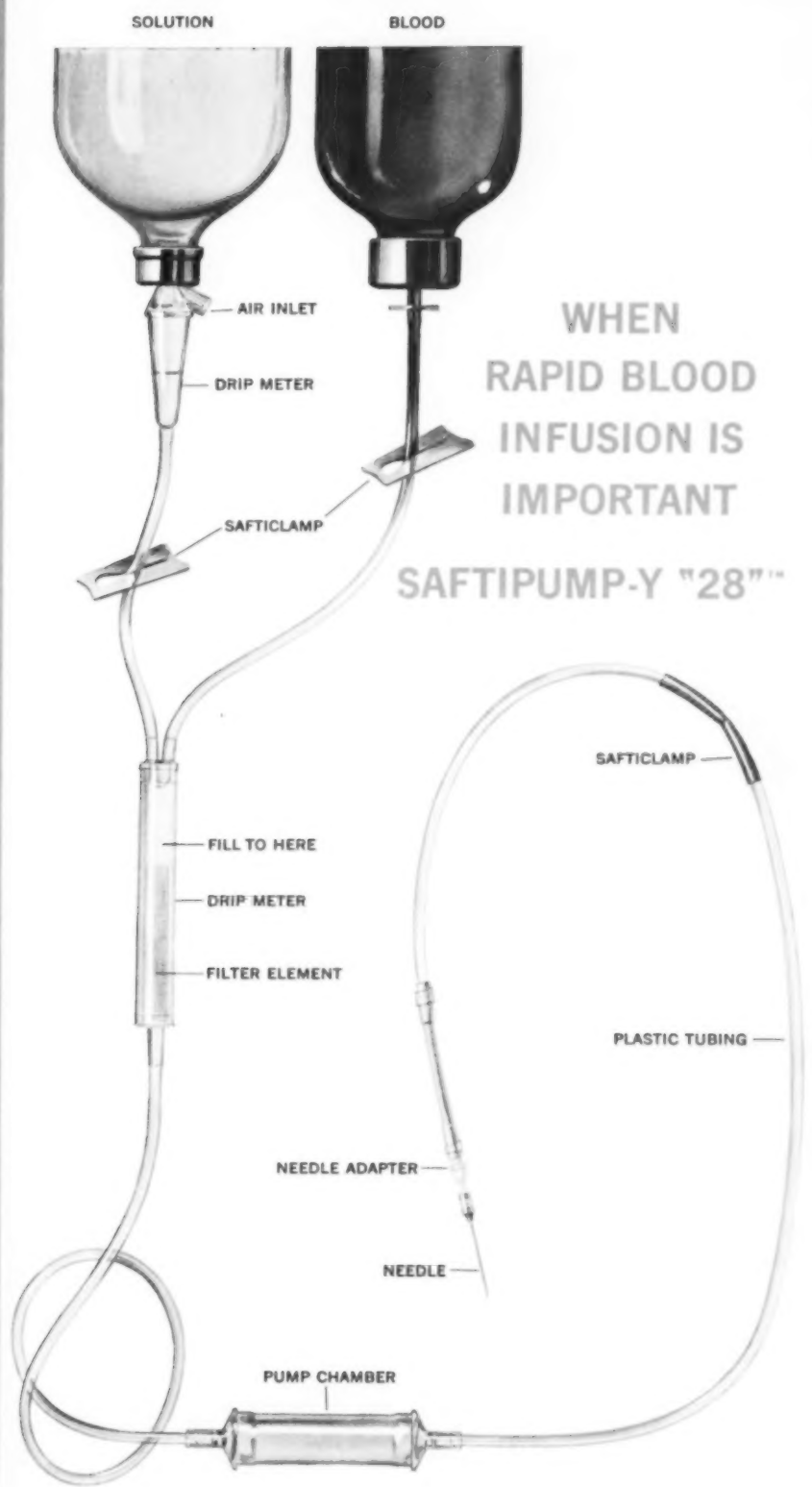
Medication can be added (aseptically) either before or after the flask has been suspended on the T stand, even after infusion is started.

Hospitals can convert to the Saftisystem "28" without confusion as it is compatible with all closed systems of I.V. administration.

SEND FOR COMPLIMENTARY WALL CHART EXPLAINING THE SAFTISYSTEM "28" IN DETAIL.

CUTTER LABORATORIES
Berkeley, California



WHEN RAPID BLOOD INFUSION IS IMPORTANT

SAFTIPUMP-Y "28"™

The manual pump of the Saftipump-Y "28" can be used for quick delivery of blood when needed.

8 second magic in I.V. set-ups with the Cutter Saftisystem "28"™†

remove metal seal and disc

plug set into center of stopper with a quick thrust

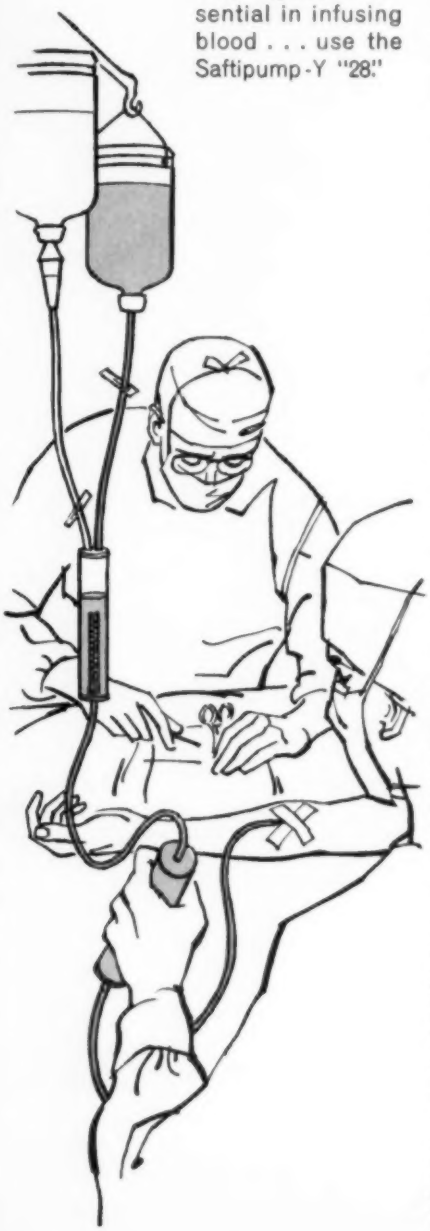
quickly invert bottle to visually check for vacuum and to automatically establish fluid level in drip chamber; clear tubing of air and infuse

†Patent Pending

SINCE CUTTER 1897

FOR RAPID BLOOD INFUSION

During surgery . . . when speed is essential in infusing blood . . . use the Saftipump-Y "28."



AT OTHER TIMES

The Saftifilter-Y "28"™ without the pumping chamber is an effective and reliable means of infusing blood under gravity.

(*Continued From Page* 102)

teresting facts emerge. For instance, chronic disease patients do not seem to know more accurately than other patients the actual disease from which they are suffering. Furthermore, while patients are generally agreed that they do not receive much information from physicians, many feel they get enough information and do not want to know more about their condition. This may be related to the patients' frequent use of denial as a psychological mechanism to keep from facing the implications of the illness and the consequent anxiety about it.

The results of this pilot study aided the research team in coming to certain decisions. From the point of view of the management, the finding of a highly favorable attitude toward the services and the staff, even in this small sample, casts doubt on the value of a larger study directed toward the same end. On the other hand, some of the other findings impressed the research team with the importance of planning research to follow up these leads.

Plan Three Projects

Three projects are now in the initial planning stages, each calculated to attack a problem emerging from the pilot study reported here. One is concerned directly with the problem of patient-physician communication. We hope to obtain experimental data on the physician's attitude toward imparting information, on how the physician's perception of the patient influences the information given, and on many other important questions in this area.

In another study, this one motivated by our finding of the small role of nurses in information transmission, we shall investigate the perceived and actual roles played by physicians, nurses and aides, as seen by each group and by patients. This study, it is hoped, will shed light on the actual roles played by these persons, discrepancies between actual and "theoretical" or traditional roles, and areas of role conflict.

Finally, because of the unclear, yet strongly felt, influence of the patient's personality on many aspects of his hospital experience and behavior, a study of the relationship of personality factors to response to illness and rate of recovery will be undertaken. ■

Write the Menu for the Readers

Ambiguous terms like "Soup of the Day," "Chef's Special," and the like are tell-tale signs of mental laziness and indicate that the menu is being improvised rather than planned

Lt. Comdr. John H. Bing, MSC, USN

CONSIDERING the emphasis these days on effective communication as a tool of hospital management, it is strange that so much is said about how to plan hospital menus and so little about how to write them. The menu is a powerful medium of communication. No other routinely issued hospital order has a larger or more interested readership, or a greater influence on hospital costs, on the utilization of employes, the satisfaction and well-being of the patients, the morale of staff members, or on the general reputation of the hospital and its administrators. Because of this, the menu should meet the basic requirement of all published writing: It should be written for its readers.

A well written hospital menu (this includes the menu for house diets, therapeutic diets, and the cafeteria) can be understood by everyone who reads it. It is clear, concise and unequivocal. It is consistent in format and terminology. It holds out no false promises to the consumer, and it gives basic but definite instructions to the employes whose work it directs.

The author is director of the Hospital Administration Division, Bureau of Medicine and Surgery, Navy Department, Washington, D. C.
The opinions and assertions contained herein are the private ones of the writer and are not to be considered as official or reflecting the views of the Navy Department or the naval service at large.

Some will argue that menus are planned and written simultaneously; but only the exceptional menu planner can do this well. Planning the menu is a creative process. Writing it is a technical process through which the planner's thoughts are expressed. Most of us do not easily transfer our exact thoughts to paper. The well written menu sometimes emerges on the first draft, but more often, like the well written letter, article or short story, it is the product of planning, writing, revising and writing again.

To planning and writing there must be added another step — that of editing — to ensure that the menu says what it means and means what it says. The proper time to put the menu to this test is before, not after, it is approved and published. Constructive editing goes far beyond reviewing the menu for misspelled words and typographical errors. It includes a critical appraisal of every item, since the menu is the sum of many parts, any of which can add to or detract from its worth.

> **"Corned beef hash is not improved by being called 'Melange O'Brien' in honor of the chef who discovered how to increase its potato content to the limit of human endurance."**

Final editing will of course include a study of the menu to be sure it meets accepted requirements of adequacy, cost, execution and acceptability. Assuming, however, that the fundamental purpose of the published menu is to advise and instruct its readers, the editing should also include an appraisal of how effectively the menu is written to accomplish this. It is this phase of editing that is sometimes overlooked because it has nothing to do with the menu planner's primary concerns with nutrition, costs and management responsibility.

Editing the menu from the standpoint of how it is written requires an appreciation of grammatical usage and a set of ground rules. There are no universal editorial rules. Rules that meet one hospital's requirements might be inadequate or unnecessary for another's. A typical editing job might consider, for example, whether the planned and written menu exhibits:

1. Correct terminology.
2. Judicious use of foreign words and phrases.
3. No unnecessary adjectives.
4. Correct use of the singular and plural.

(*Continued on Page* 108)

Sexton knows where the finest grows

from Maine to California!

Quality doesn't just happen . . . and the juicy, plump, tender vegetables which bear the Sexton label didn't come to us by chance. Our buyers locate the finest crops wherever they grow, from Maine to California.

You can count on Sexton to find the most flavorful vegetables for you . . . to process them perfectly and seal in their field-fresh flavor . . . and to deliver them promptly on your order. At Sexton, quality is a tradition carefully built through generations of serving the volume food market.

Sexton

Quality Foods

JOHN SEXTON & CO.

Serving the volume feeding market since 1883

THE MENU IS A PROMISE

5. Freedom from ambiguity.
6. Consistency of format.
7. Accuracy and completeness.

These requirements might apply to the editing of any copy destined for publication, but they have a particular relevancy to the hospital menu.

Correct Terminology

No menu planner (let us hope) would deliberately misrepresent, but some may exhibit an occasional human tendency to favor euphemisms for factual English. For example, hamburger is "hamburger" or, at best, "ground beef." It is never "ground round steak" or "chopped sirloin" unless the round or sirloin tip was involved in the preparation and service, as well as in the planning of the item.

The urge to name dishes after the hospital cooks who develop recipe variations should be restrained. While it is no doubt fundamentally sound personnel psychology, the introduction of unfamiliar names into the menu is confusing to the readers. In any case, "corned beef hash" is not improved by calling it "Melange O'Brien" in honor of the chef who discovered how to increase its potato content to the limit of human endurance.

The menu planner may also forget sometimes that his understanding of foods is usually greater than that of those who read the menu. What is correct terminology to him may be something else to the reader. "Cushion roast of lamb" offers a case in point. Here is a perfectly good term if everyone understands it. The decision to change it to "roast stuffed shoulder of lamb" or to leave it alone is an editorial responsibility.

Imagination, which plays such an important part in the planning of menus, should be forgotten when writing them. The tough, outer stalks of celery are not magically tenderized by being described as "celery hearts." The popularity of a good, honest beef stew depends almost entirely on its ingredients and its preparation; listing it as "braised beef cubes with fresh vegetables" does not necessarily contribute to its consumer acceptance. Speaking of vegetables, the factual "mixed vegetables" is to be preferred to the more romantic "medley of vegetables" or to the more exotic "macedoine of vegetables," particularly if the consumers are already aware that the cooks use the same recipe for all three.

Foreign Words and Phrases

The rule here is simple. Avoid foreign words and phrases whenever a suitable English expression can be used instead. The application of the rule is somewhat less simple, however. The language of food is international and we use many foreign terms that are understood by a majority of patients and employes, *i.e.* au gratin, croquettes, filet mignon. The test of the suitability of using foreign words and phrases is whether they are comprehended by those who read the menu. It is for the editor to anticipate whether the patient in Room 212 (who dislikes cream in any form) will be justified in complaining about her misguided choice of a dish listed as "a la Chantilly" on her selective menu form.

The temptation to use foreign terms in hospital menus is sometime strong because of their frequent appearance in hotel and restaurant menus. The prosaic "breaded veal cutlet" is the American cousin of "weiner schnitzel," and both are related to a pretty French dish called "escalope de veau a la viennoise." But such outside influences should be resisted. Today's hospital menu owes much to its ancestors, the hotel and restaurant menus, but unlike them it functions only to describe food, not to sell it or to enhance the atmosphere in which food is prepared and served.

Adjectives

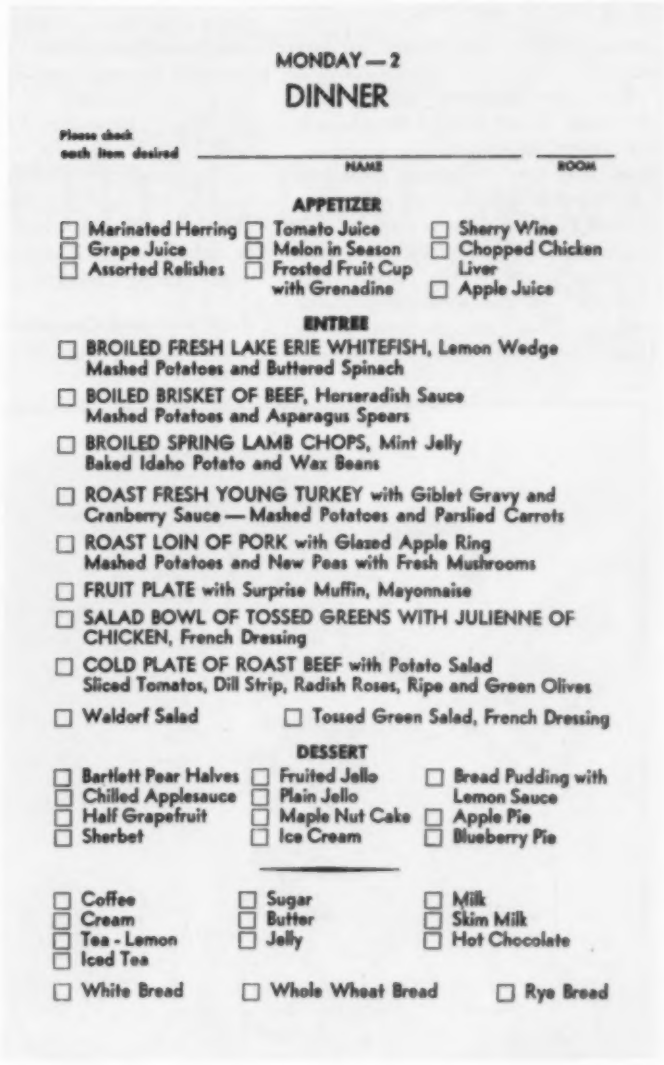
The hospital menu is an organized collection of nouns and adjectives. The former should be used correctly and the latter not only correctly, but sparingly. A good rule in using adjectives is to remember that every word in the menu is a promise. Why make any more promises than have to be made?

The use of adjectives should be restricted to (1) providing essential information about how something should be prepared or served, or (2) identifying an item which, unmodified, might be confused with other items of a similar nature.

In the first instance, it is redundant to say *hot* coffee. Cooks and coffee addicts would not expect it to be served any other way. *Iced* coffee is something else, and the adjective is required or hot coffee will be served instead. Likewise, *iced* tea, *hot* apple pie, *stewed* tomatoes, *sliced* tomatoes, *broiled* tomatoes, all illustrate economical but essential use of adjectives that give basic instructions to the cooks and give the consumer some forewarning of what to expect.

Only a step beyond is a dangerous area where the menu planner's facts may be replaced by his conclusions. Very little can improve on the factual "fried shrimp," for example. Certainly not some of its possible variations: "*golden* fried shrimp (?),

TO THE PATIENT



MONDAY — 2

DINNER

Please check each item desired

NAME _____ ROOM _____

APPETIZER

☐ Marinated Herring ☐ Tomato Juice ☐ Sherry Wine
☐ Grape Juice ☐ Melon in Season ☐ Chopped Chicken Liver
☐ Assorted Relishes ☐ Frosted Fruit Cup with Grenadine ☐ Apple Juice

ENTREE

☐ BROILED FRESH LAKE ERIE WHITEFISH, Lemon Wedge
Mashed Potatoes and Buttered Spinach

☐ BOILED BRISKET OF BEEF, Horseradish Sauce
Mashed Potatoes and Asparagus Spears

☐ BROILED SPRING LAMB CHOPS, Mint Jelly
Baked Idaho Potato and Wax Beans

☐ ROAST FRESH YOUNG TURKEY with Giblet Gravy and Cranberry Sauce — Mashed Potatoes and Parslied Carrots

☐ ROAST LOIN OF PORK with Glazed Apple Ring
Mashed Potatoes and New Peas with Fresh Mushrooms

☐ FRUIT PLATE with Surprise Muffin, Mayonnaise

☐ SALAD BOWL OF TOSSED GREENS WITH JULIENNE OF CHICKEN, French Dressing

☐ COLD PLATE OF ROAST BEEF with Potato Salad
Sliced Tomatos, Dill Strip, Radish Roses, Ripe and Green Olives

☐ Waldorf Salad ☐ Tossed Green Salad, French Dressing

DESSERT

☐ Bartlett Pear Halves ☐ Fruited Jello ☐ Bread Pudding with Lemon Sauce
☐ Chilled Applesauce ☐ Plain Jello ☐ Apple Pie
☐ Half Grapefruit ☐ Maple Nut Cake ☐ Blueberry Pie
☐ Sherbet ☐ Ice Cream

☐ Coffee ☐ Sugar ☐ Milk
☐ Cream ☐ Butter ☐ Skim Milk
☐ Tea - Lemon ☐ Jelly ☐ Hot Chocolate
☐ Iced Tea

☐ White Bread ☐ Whole Wheat Bread ☐ Rye Bread

Highland Park Hospital, Highland Park, Ill., provides its patients with a menu that is clear and easy to understand.

luscious fried shrimp (?), fried *gulf* shrimp(?). These nonessential adjectives contribute nothing to the preparation of the dish or to the consumer's enjoyment of it.

Adjectives are also useful, if not essential, in identifying an item that might be mistaken for something else. Some delineation is required between fresh plums and canned plums; between fresh corn, canned corn, and fresh-frozen corn; between fresh ham and smoked ham, and between many other items that may be purchased in a variety of market forms. Denoting the desired form by adjectives or abbreviations on the menu saves much confusion all along the long trail that begins with the menu planner's thought and leads to the consumer's ultimate satisfaction.

Singular and Plural

While this may seem a minor point, it is unfair to write "broiled lamb chops" if it is management's intention that one chop (even a large one) constitutes a serving. Listing steaks, chops, cutlets, fillets, doughnuts, sweet rolls, and cupcakes is entirely proper if two or more pieces are served, but the plural form promises too much if the house rule is only one to a customer. Indiscriminate use of the singular or plural, *i.e.* without realizing its importance, shows that the menu planner is hazy about hospital procurement policies and standard portion sizes. This fuzzy thinking is bound to confuse everyone who reads the menu.

Consistency of Format

This requirement comes about because the menu is a repetitive order frequently referred to by more or less the same people day after day. Although the nouns and adjectives in the menu change from meal to meal, it is essential that the basic components of each meal be listed in unvarying sequence, as in the example below:

Appetizer or soup
Main dish
Gravy or sauce
Potatoes
Vegetables
Salad
Dessert
Breads
Butter
Beverage

Once a menu pattern such as this is established, it should not be altered by whim or carelessness. Shifting the sequence of components makes the menu more difficult to check for completeness and more difficult for the employes and consumers to read.

Freedom From Ambiguity

Inexact terminology, foreign words and phrases, unnecessary adjectives, the addition or omission of an "s," and inconsistent format all weaken the communication potential of the published menu. But none of these impair communication like the completely ambiguous terms sometimes encountered in menus – the tell-tale

signs of mental laziness – like "soup of the day," "chef's special," "ice cream," "fresh fruit," and "cooked cereal."

Such generalizations indicate that the menu is not being fully planned but rather improvised to accommodate inventory surpluses, slipshod procurement policies, or the menu planner's lack of time or interest. The real danger of ambiguous terms such as these is not in the obvious fact that they tell the consumer little or nothing. Their nonspecificity allows procurement and production personnel to share in the planning of the menu *after* it is published and permits them to improvise on the menu planner's thoughts rather than carry them out according to specific instructions. The well written menu is both a work order for the employes and a statement of policy for the hospital. It should instruct the employes and permit them no leeway to make policy that is contrary to the menu planner's intentions.

Accuracy and Completeness

Editorial review of the menu should always include a thorough check of the final draft to ensure that items have not been lost in the transition from the rough draft. Spelling should be checked. Misspelled words in the published menu can undermine the reader's confidence, no matter how sound the planning that went into the menu.

In summary, what the consumer wants most in the hospital menu is honest language that he understands. He regards the menu as a sort of promissory note, payable to him on demand. Writing the menu so he can understand it protects him from unnecessary disappointment and protects management from needless attacks on its motives and reputation. The menu must also be written to instruct the employes who prepare and serve the meals. Good writing cannot save a poorly planned menu but it can enhance whatever planning goes into the menu.

Effective communication through the menu is essential to maximum consumer acceptance of the meals and diets and to guiding the food service employes to a common goal – the very best food the hospital can serve. ■

FOOD FOR THOUGHT

Here's New Wrinkles for Prunes

Prunes have become sophisticated. Instead of served plain, in a humdrum fashion, they are being used to add appetite appeal to economy dishes, provide color contrasts, or serve as a flavoring agent for meat, salads and desserts.

Prune juice is fine for breakfast but is also a flavorful liquid for cooking pot roast, Swiss steak, and pork chops.

To perk up summer appetites, arrange prunes stuffed with cream cheese on lettuce, or melt butter over pitted prunes to give an unusual taste and texture to broiled fowl or pork.

As a main dish, try a mixture of prunes, juice, sugar, and orange rind, on bread slices. Toast one side; on untoasted side place cheese, return to broiler, and remove when melted.

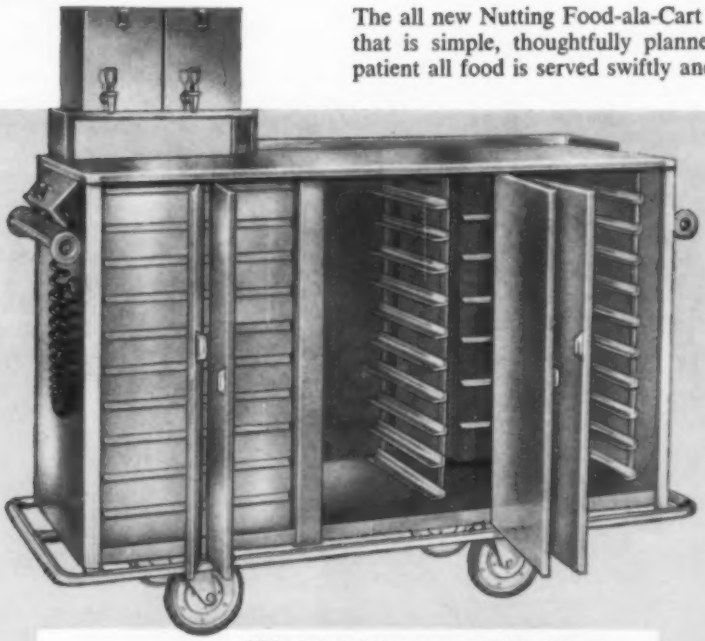
Prunes are economical in cost per portion and are available all year-round because of many new processing methods, according to the California Prune Advisory Board, which suggested the new uses.

new idea streamlines
hospital food service

Nutting FOOD-ala-CART System

ends "DIET TRAY CONFUSION!"

The all new Nutting Food-ala-Cart gives your hospital a food service system that is simple, thoughtfully planned and easy to follow. From kitchen to patient all food is served swiftly and more easily with Food-ala-Cart.

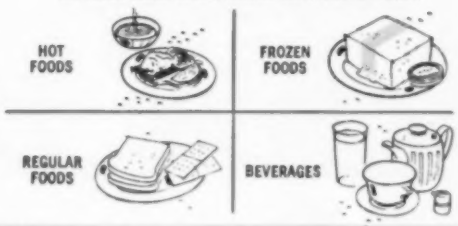


Food-ala-Cart ends diet tray confusion because there is only one serving per oven drawer and this matches its own serving tray . . . there's absolutely *no chance* of mix-up or confusion!

Food-ala-Cart also improves the appetite appeal of food because it has three separate temperature zones ranging from "piping hot" to "cold" to "deep freeze." All foods reach patients at the peak of flavor and nutrition and at dietetically approved serving temperatures.

Your hospital food service system will function more smoothly with Nutting Food-ala-Cart on the job. This equipment is the "key" that unlocks the door to well-balanced food service and makes everyone, from the dietition to the patient to the physician, happier and more satisfied with food preparation and service. Write today for complete facts about this newest idea to streamline your hospital food service.

All foods taste better served via FOOD-ala-CART!



FREE brochure gives you 18 good reasons why Food-ala-Cart outperforms ordinary food service equipment. CLIP and MAIL COUPON TODAY.

Other types of Nutting hospital equipment:


(Fig. 1989)
MOBILE ICE CHEST


(Fig. 1919-ST)
SHELF TRUCK


(Fig. 507)
REFUSE CAN TRUCK


(Fig. 1154-GR)
GLASS RACK AND
MILK CASE DOLLY


(Fig. 892)
LINEN AND
LAUNDRY TRUCK


(Fig. 845)
PLATFORM TRUCK


(Fig. 863-LW)
ROUND CONTAINER
DOLLY


(Fig. 1152)
TWO WHEEL TRUCK

FOOD-ala-CART SERVICE
Nutting Truck & Caster Co.
1042 Division Street, Faribault, Minn.

Please send —

☐ Latest information about Food-ala-Cart service

☐ Information on Fig. _____ Trucks

Name_____

Hospital_____

Address_____

City_____ State_____

For additional information, use postcard facing back cover.

Cost Comparisons for Food Service Should Be Taken With a Pinch of Salt

By Jane Hartman

WITH 20 per cent of the hospital budget spent in the food service department, the dietitian must accept her part in protecting the patient's economic as well as his nutritional welfare.

Budgeting and cost analysis are two basic tools of financial management. The former establishes guidelines, a financial frame of reference. The latter provides the detailed data from which each of the cost elements can be studied.

It is essential that the dietitian be involved in the processes of budgeting and cost analysis. She should not delegate her share of the responsibility to the administrator, business manager, or accountant.

Vital as are both processes, the temptation on the part of either the dietitian or her administrator to measure performance by comparing data with other hospitals must be seasoned with a pinch of salt. Comparison *can* be undertaken when reliable cost analysis is undertaken.

While the raw food cost per person per day is one measure of dietary expense that is comparable within a given area, even this will be affected by the level of service desired by individual hospitals. **Here are some other factors that the dietitian will recognize as affecting comparability among hospitals:**

1. The type of food distribution system in use influences cost. A recent study of centralized and decentralized tray service revealed that the centralized tray service in the study hospital was more economical.* Centralized tray service required fewer minutes of direct personnel time and consequently less labor cost per tray delivered than did the decentralized tray service.

2. Administrative policy concerning personnel food service varies in hospitals. Traditionally, personnel cafeterias and staff dining facilities have operated at a loss. This deficit has been written off as an employe fringe benefit. However, this should be written administrative policy.

Ideally, the dietitian operates the personnel cafeteria independent of patient food service. Labor hours and raw food cost as well as supplies and overhead should be prorated to obtain a realistic cost picture of personnel feeding. When the administration advocates a break-even policy, the dietitian must maintain adequate records to substantiate the markup over raw food cost necessary to approximate the cost of operation.

3. Catering is a significant factor in dietary costs. It is important to calculate the cost of every "special function." This report should include the raw food cost of menu items and the wages and salaries of personnel involved, in order to determine labor cost and supplies expended. Catering is not a fair or justifiable charge against patient food service.

4. The layout and equipment in the food service department contribute to efficiency of operation, or the lack of it. The capacities and kinds of equipment determine purchasing procedures. For example, if freezer space is limited, the dietitian cannot take advantage of good buys in frozen food items. The extent to which automation has been employed in dishwashing, pot washing, vegetable preparation, and so on, are variables in dietary expense. The distance that food must be transported is another consideration, as is the number of kitchens and serving pantries.

5. Personnel policies influence dietary costs. If labor turnover is high, the cost of training new employes is significant. On the other hand, many dietary workers may be receiving maximum salaries because of long service. Some hospitals furnish meals and uniforms as fringe benefits for dietary personnel, and there may be no charge for laundry of uniforms.

6. The scope of service to patients varies in hospitals. Dietary personnel may be involved in distribution of trays, feeding of patients, and return of soiled trays. The teaching dietitian may be charged to nursing service and her salary may be shared. Between-meal nourishments may be served by nursing or dietary personnel. Selective menus may be distributed and collected by hospital volunteers.

The wise dietitian is fully aware of these and numerous other reasons for variations in dietary expense. Financial management is one of the tangible measures of efficiency. ■

*Thompson, John D.; Hartman, Jane, and Pelletier, Robert J.: Two Types of Tray Service Studied Side by Side. A cooperative study under United States Public Health Service Grants W 53 C and W 7 (C2). Hospitals 34: 82 (Feb. 1) and 34: 82 (Feb. 16) 1960.

This is the first of a series of monthly columns by Jane Hartman, newly appointed food service consultant to The Modern Hospital. For many years a hospital dietitian, Miss Hartman now serves the field as a consultant. She is also coordinator of educational institutes for the American Dietetic Association and chairman of the institute administrative section of the American Home Economics Association. A graduate of West Virginia University, with a master's degree from Drexel Institute, Philadelphia, Miss Hartman has been chief dietitian at Torrence State Hospital, Torrence, Pa., and Sinai Hospital, Baltimore. She served for 10 years as consulting dietitian and food service director for the Maryland State Department of Health and for several years was food service specialist on the staff of the Connecticut Hospital Association.

Mass Feeding Systems:

What's the real cost?

In an era marked by constantly increasing costs, food service experts are taking a closer, more studied approach to the selection of food service equipment. And with good reason: unwarranted over-the-years expenses, unless rigidly controlled, can equal many times the initial investment in equipment.

Today, as never before, these men are insisting upon the combination of quality fabrication and astute design. *Quality fabrication* to assure at least 25-30 years of replacement-free service. *Astute design* for efficient work-flow...few operating personnel...minimum maintenance, obsolescence, and sanitation costs.

This, more than anything else, is the reason behind the growing number of installations by Blickman.

Blickman installations are actually paying for themselves many times over by delivering extra years of low-cost service. We'll be glad to work with your building team (architect, contractor or consultant) in solving your particular mass feeding problem.

Modern functionalism is the keynote of this Blickman cafeteria counter at a prominent New York hospital. Unique "pedestal" design opens up entire serving area, gives a fresh, uncluttered appearance, reduces clean-up operation. Seamless, welded one-piece surfaces plus clean-line design enhance sanitation and assure lasting beauty. Plumbing and utilities easily accessible to simplify maintenance. Stainless steel construction for long life, low replacement costs.

25-year old Blickman installation justifies initial cost. Little the worse for all its 25 years of rugged use, this Blickman kitchen is still going strong at the Jersey City Medical Center. Note rounded corner construction...seamless joints...one-piece, crevice-free surfaces. For details and our new folder, "Planning Equipment for Mass Feeding," write: S. Blickman, Inc., 1507 Gregory Avenue, Weehawken, N. J.

BLICKMAN
FOOD SERVICE EQUIPMENT

Look for this symbol of quality... Blickman-Built

See us at the American Hospital Association Convention in San Francisco, August 29—September 1, Booth 1307.

For additional information, use postcard facing back cover.

Menus for August 1960

Sister Mary Denise
Food Service Director
Mercy Hospital
Bakersfield, Calif.

1

Applesauce
Ham Omelet, Muffins
•
French Onion Soup
Roast Veal
Steamed Potatoes
Buttered Squash
Vanilla Pudding
•
Beef Broth With Rice
Beef Pattie
Baked Potato
Molded Lime-Pear Salad
With Cream Cheese
Dressing
Gelatin Dessert

2

Orange Juice
Bacon, Coffee Cake
•
Beef Noodle Soup
Meat Loaf
Mashed Potatoes
Buttered Green Beans
Vanilla Ice Cream
•
Tomato Juice
Broiled Lamb Chop
Baked Potato
Buttered Asparagus
Sliced Orange and
Stuffed Prune Salad
Cottage Pudding With
Vanilla Sauce

3

Cantaloupe
Soft Cooked Eggs
•
Julienne Vegetable Soup
Roast Beef, Gravy
Mashed Potatoes
Buttered Peas
Stewed Fruit
•
Cream of Celery Soup
Baked Cube Steak
With Mushroom Sauce
Baked Potato
Buttered Shoestring Beans
Cottage Cheese-Pineapple
Salad
Stewed Peach

4

Half Grapefruit
Bacon
•
Tomato Rice Soup
Roast Chicken, Gravy
Cornbread Dressing
Mashed Potatoes
Buttered Spinach
Fresh Fruit Ambrosia
Baked Caramel Custard
•
Fruit Juice
Beef Pattie
Parslied Potato
Boiled Carrots
Waldorf Salad
Stewed Fruit

5

Kadota Figs
Hot Cakes, Sirup
•
Tomato Clam Chowder
Macaroni and Cheese
Mashed Potatoes
Scalloped Tomatoes
Tapioca Pudding
•
Cream of Asparagus Soup
Tuna-Noodle Casserole
Baked Potato
Diced Beets
Tossed Green Salad
Gelatin Dessert

6

Orange Juice
Poached Egg
•
Vegetable Soup
Roast Lamb
Steamed Potatoes
Fresh Asparagus
Fresh Fruit Cup
Vanilla Pudding
•
Fruit Juice
Creamed Chicken on Toast
Baked Potato
Mixed Vegetables
Molded Pineapple and
Carrot Salad
Sherbet

7

Half Grapefruit
Bacon, Roll
•
Beef Noodle Soup
Fried Chicken
Mashed Potatoes
Corn on the Cob
Buttered Whole Beets
Vanilla Ice Cream
•
Fruit Juice
Broiled Lamb Chop
Parslied Potato
String Beans
Molded Fruit Salad
Applesauce Cake

8

Orange Juice
Ham Omelet, Muffins
•
Cream of Celery Soup
Roast Veal
Steamed Potatoes
Buttered Lima Beans
Berry Cobbler
•
Beef Broth With Rice
Beef Pattie
Baked Potato
Fresh Peas
Deviled Egg-Tomato
Wedges
Gelatin Dessert

9

Banana Slices
Bacon, Coffee Cake
•
Corn Chowder Soup
Grilled Liver with
French Fried Onion Rings
Mashed Potatoes
Buttered Zucchini
Stewed Fruit
•
Fruit Juice
Chicken Fricassee
Baked Potato
Mixed Vegetables
Grapefruit-Avocado Salad,
French Dressing
Ice Cream

10

Whole Peeled Apricots
Poached Egg
•
Potato Chowder
Roast Beef, Brown Gravy
Mashed Potatoes
Buttered Spinach
Snow Pudding
•
Tomato Juice
Sausage, Apple Rings
Baked Potato
Buttered Zucchini
Pear, Grated Cheese Salad
Orange Sunshine Cake

11

Applesauce
Bacon, Orange Muffins
•
Tomato Bouillon
Roast Chicken, Gravy
Mashed Potatoes
Buttered Beans
Gelatin Dessert
•
Chicken Noodle Soup
Meat Pie
Parslied Potato
Boiled Carrots
Tomato-Asparagus Salad
Stewed Peaches, Cookies

12

Honeydew Melon
French Toast, Sirup
•
Tomato Clam Chowder
Grilled Filet of Sole
Mashed Potatoes
Scalloped Tomatoes
Apple-Cheese Crisp
•
Chilled Grape Juice
Salmon Salad
Potato Chips
Buttered Zucchini
Pear With Cream Cheese
Gelatin Dessert

13

Stewed Prunes
Poached Egg
•
Vegetable Soup
Corned Beef
Steamed Potatoes
Buttered Spinach
Fresh Fruit Cup
Vanilla Pudding
•
Cream of Celery Soup
Beef Pattie
Baked Potato
Buttered Peas
Sherbet

14

Grapefruit Half
Bacon, Sweet Roll
•
Beef Noodle Soup
Roast Chicken
Mashed Potatoes
String Beans
Vanilla Ice Cream
•
Tomato Rice Soup
Broiled Lamb Chop
Baked Potato
Red Kidney Bean Salad
Banana Cake

15

Grapefruit-Orange
Sections
Cinnamon Toast
•
Chicken Rice Soup
Roast Beef, Brown Gravy
Mashed Potatoes
Harvard Beets
Ice Cream, Cookies
•
Cream of Celery Soup
Scalloped Chicken
Parslied Potato
Buttered Parsley Carrots
Molded Lime and
Cottage Cheese Salad
Orange Sunshine Cake

16

Banana Slices
Bacon, Blueberry Muffins
•
Potato Chowder
Roast Lamb, Mint Jelly
Mashed Potatoes
Baked Banana Squash
Rice Pudding
•
Cream of Corn Soup
Beef Pattie
Baked Potato
Mixed Vegetable
Grapefruit-Avocado
Salad With French
Dressing
Orange Frosted Cupcake

17

Orange Juice
Sausage, Scrambled Eggs
•
Vegetable Noodle Soup
Cheese Souffle
Mashed Potatoes
Buttered Asparagus
Vanilla Ice Cream
•
Cream of Pea Soup
Beef-Noodle-Cheese
Casserole
Baked Potato
Buttered Green Beans
Cottage Cheese and
Pineapple Salad
Stewed Peach

18

Half Grapefruit
Bacon, Orange Muffins
•
Tomato Rice Soup
Roast Turkey, Gravy
Mashed Potatoes
Broccoli With Cheese
Sauce
Baked Coconut Custard
•
Chicken Noodle Soup
Poached Egg on Rice
Parslied Potato
Boiled Carrots
Tomato-Asparagus Salad
Chocolate Pudding

19

Orange Juice
French Toast, Sirup
•
Clam Chowder
Fried Scallops
Mashed Potatoes
Creamed Peas
Stewed Fruit
•
Cream of Mushroom Soup
Seafood Casserole
Baked Potato
Tossed Green Salad
Peanut Butter Cookies

20

Applesauce
Poached Egg, Doughnut
•
Vegetable Soup
Baked Ham, Raisin Sauce
Buttered Spinach
Fresh Fruit Cup
Vanilla Cup Pudding
•
Cream of Celery Soup
Baked Ravioli
Buttered String Beans
Tomato Salad
Stewed Peaches
Cookies

21

Orange Juice
Bacon, Sweet Roll
•
Beef Noodle Soup
Roast Chicken, Gravy
Spiced Apple
Mashed Potatoes
Cauliflower With
Cheese Sauce
Vanilla Ice Cream
•
Tomato Rice Soup
Broiled Lamb Chop
Baked Potato
Buttered Asparagus
Beet and Egg Salad
Stewed Pears

22

Orange Juice
Sausage Links
•
Chicken Rice Soup
Roast Beef, Brown Gravy
Oven Browned Potatoes
Buttered Summer Squash
Lemon Meringue Pudding
•
Cream of Celery Soup
Macaroni and Cheese
Baked Potato
Buttered Carrots
Stuffed Prunes With
Cream Cheese
Baked Custard

23

Grapefruit Sections
French Toast, Sirup
•
Julienne Vegetable Soup
Roast Veal
Scalloped Potatoes
Buttered Asparagus
Stewed Fruit
•
Cream of Pea Soup
Beef Pattie
Baked Potato
Buttered Peas
Ambrosia Salad
Sherbet

24

Prunes
Ham Omelet, Muffins
•
Vegetable Soup
Plain Meat Loaf
Mashed Potatoes
Green Beans
Pears
•
Chicken Rice Soup
Lamb Chop
Diced Beets
Tomato Aspic With
Sour Cream Dressing
Fruit Compote

25

Apricots
Bacon, Orange Muffins
•
Tomato Rice Soup
Roast Turkey, Gravy
Cornbread Dressing
Mashed Potatoes
Celery With Cheese
Sauce
Blueberry Crumb Pudding
•
Chicken Noodle Soup
Canadian Bacon Slices
Baked Potato
Boiled Carrots
Tomato-Asparagus Salad
Stewed Fruit, Cookies

26

Banana Slices
Scrambled Eggs
•
Tomato Clam Chowder
Filet of Sole
Mashed Potatoes
Buttered Spinach
Lemon Meringue Pie
•
Tomato Juice
Shrimp Creole, Rice
Baked Potato
Buttered Green Peas
Pear With Cream Cheese
Center
Sherbet

27

Orange Juice
Poached Egg
•
Vegetable Soup
Roast Lamb
Steamed Potatoes
Buttered Carrots
Vanilla Pudding
•
Cream of Celery Soup
Spaghetti and Meat Balls
Buttered Asparagus
Tomato Salad
Gelatin Dessert

28

Half Grapefruit
Bacon, Sweet Roll
•
Beef Noodle Soup
Baked Chicken
Mashed Potatoes
Baby Lima Beans
Vanilla Ice Cream
•
Fruit Juice
Cold Plate: Meat and
Cheese
Potato Chips
Green Beans
Molded Fruit Salad
Applesauce Cake

29

Orange Juice
Ham Omelet, Muffins
•
Vegetable Soup
Barbecued Pork Chop
Steamed Potato
Buttered Squash
Stewed Peaches
•
Beef Broth With Rice
Chicken Fricassee
Baked Potato
Buttered Carrots
Tossed Green Salad
With Sour Cream
Dressing
Gingerbread

30

Rhubarb Sauce
Bacon, Coffee Cake
•
Beef Noodle Soup
Roast Lamb
Mashed Potatoes
Buttered Whole Beets
Cheese Cake
•
Fruit Juice
American Chop Suey
Mixed Vegetables
Pineapple With Grated
Cheese
Broiled Half Grapefruit
With Brown Sugar

31 Prunes, Ham Omelet • Cream of Asparagus Soup, Meat Loaf, Parslied Potatoes, Buttered Peas, Fresh Fruit Ambrosia, Custard • Chicken Rice Soup, Scalloped Ham and Peas, Baked Potato, Buttered Green Beans, Tossed Green Salad With French Dressing, Sherbet

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Height: 31½"
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No. 436
Stainless Steel
400-lbs. capacity
Shelf-size:
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Stainless Steel
500-lbs. capacity
Shelf-size: 21"x35"
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5" casters

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Stainless Steel
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Height: 50"
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Height: 32¼"

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Who Should Disinfect Bedding and How

Proper disinfection requires not only sound technics, as discussed in the author's earlier articles, but a physical setup that will assure that the work is carried out effectively

Wolfgang Haas

IT IS extremely important that the blanket and pillow have been rendered free of harmful organisms before being given to the newly admitted patient. It may be futile to disinfect these items, however, if steps are not taken to clean the remainder of the patient's environment. This does not mean that, in the absence of an adequate infection control system, no attempt should be made to disinfect blankets and pillows. It does mean that this should be the beginning of a thorough program of hospital sanitation.

Consider All Bedding

Although this study was limited specifically to disinfection of blankets and pillows, the importance of disinfection of beds, mattresses, sheets, pillowcases and bath blankets cannot be overlooked. Recommended practices will therefore be outlined briefly, with no attempt to discuss details, show needs, or compare alternatives.

1. Beds. After the discharge of every patient (and possibly during his stay) the bed should be wiped with a disinfectant. Items which are attached to the bed, such as siderails and I.V. stands, must also be wiped with a disinfectant when they are removed from the bed.

In a hospital with a bed shortage, there will be pressure to prepare the unit for a new admission. This pressure should not be allowed to prevent the personnel from cleaning a patient unit properly after discharge.

The importance of following the prescribed disinfection technics must be taught to the workers.

2. Mattresses. Because they are so difficult to disinfect, mattresses should be protected from contamination. The cover that is used must protect not only the top, but also the sides and adjacent portions of the bottom of the mattress. Mattress covers of various materials may be used.

Plastics and rubber are widely used as mattress covers. These should be wiped with a disinfectant when the unit is prepared for a new admission. Because they are impervious, mattress covers of plastic or rubber may make the mattress uncomfortably damp for the patient. Placing a bath blanket between the mattress cover and the sheet can alleviate this problem.

Colbeck has recommended the use of a ticking mattress cover which is washed and impregnated with mineral oil and a quaternary ammonium compound.* The mattress is furnished with a fresh cover for each patient. The oil acts as a barrier to dust; the disinfectant destroys microorganisms which settle on the mattress cover if there is moisture present.

3. Sheets, Pillowcases and Bath Blankets. The routine laundry procedure for the washing of cotton has been generally found to produce a virtually sterile product. Satisfactory technics are described, in detail, in the literature. To be safe, the products of the laundry should be periodically subjected to bacteriological study.

Care must be taken to assure that bedding that has been disinfected during the laundry cycle is not recontaminated before reaching the bed.

Who Is Responsible?

After deciding what is to be done to prevent the spread of infection by blankets and pillows, the department that is to be responsible for the disinfecting procedure must be selected. Steps must be taken to assure that each blanket and pillow is subjected to the selected procedure. Tests must also be performed to check on the efficacy of the disinfecting procedure that the hospital is using.

Assignment of Work. If disinfection takes place as part of the washing cycle, there is no problem in deciding where the work is to be done or who is to be responsible

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Continuing an article on disinfection of pillows and blankets condensed from a master's thesis prepared by Mr. Haas as part of the program in hospital administration at the University of Michigan. The first two sections appeared in the May and June issues.

Mr. Haas is administrative assistant and office manager of Sherman Oaks Community Hospital, Sherman Oaks, Calif.

*Colbeck, J. C.: Studies in Hospital Infections, I., The Importance of Staphylococcal Disease. Canad. Serv. M. J. 12:563 (July-August) 1956.

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for its performance. The laundry is the obvious answer.

If ethylene oxide has been selected as the disinfectant, there are several departments to which the work can be assigned. There are arguments both for and against using the central sterile supply department, if the hospital has one, for this purpose. The arguments *pro* are based generally on the availability of equipment, trained personnel, and supervision for this type of work. The arguments *con* are based on one primary consideration.

Blankets, especially those containing wool, give off considerable amounts of lint when handled. Such lint is considered by some to provide a superior form of transportation for the microorganisms which may be found on the blanket. Thus, handling blankets (and feather pillows are probably not much better) in central sterile supply can be a source of serious contamination in an area which should be as clean as possible.

It has been suggested that the gas disinfection unit should be located in the laundry or in a separate disinfection unit to be operated by housekeeping or nursing service personnel. The laundry is a logical location since this is where the hospital's textiles are processed and dirty blankets are washed. Alternatively, if the housekeeping department is responsible for stripping a room after the patient's discharge, there would be a logical reason for this department to disinfect the blankets and pillows, as well as other patient utensils, before returning them to storage or to use. The fact that nursing personnel has training in disinfection and sterilization procedures could justify making nursing service responsible for the disinfection unit.

The weight of argument would seem to indicate that gas disinfecting equipment should be located in and operated by the personnel of central supply. The reasons for this conclusion are that the personnel there is trained in the operation of this type of equipment. Also, and this may be more important, the sterile supply supervisors have training and a professional background in principles and technics of sterilization. The average housekeeping supervisor or laundry manager is not likely to have, or to acquire, competence in this area comparable to that of the supervisor who is concerned every day with problems of sterilization and who will probably have had special training in this field.

If an ethylene oxide disinfector is being used, another argument for the use of central supply is economy. Since the equipment is quite expensive it should, if possible, be available for other uses. This could be most readily accomplished by having the gas sterilizer installed and used in the central supply room.

The undesirable element of handling blankets and pillows in central supply could be eliminated by having them handled, sorted, folded and stacked on trucks or in bundles outside (probably in the laundry), so that they can be put into the sterilizer without further handling. In this way, central supply would get a truck or bundle which it would process and return without becoming involved in collection, accounting, inspection or distribution.

Applies to General Bedding

This study has been concerned with bedding for general patient use. It is not intended, therefore, to imply that the conclusions necessarily apply to material that has been used by an isolation patient.

Anyone wishing to test or institute the procedures discussed is cautioned to refer to the original articles for the details of the procedures followed. An apparently minor change can lead to results quite different from those reported. For example, a certain type of chemical disinfectant becomes quite ineffective in the presence of one kind of detergent.

It should be emphasized that the experiments of others, the claims of manufacturers, or the diligent following of instructions are no proof that a specific technic of disinfection is effective. There is no substitute for continuing surveillance of the procedures that are followed, not only by operating and supervisory personnel (to assure that the prescribed procedures are being followed), but by continuing bacteriological testing of areas which could become sources of infection.

Each hospital should periodically review its practices in the area of handling and disinfecting blankets and pillows, including a bacteriological study of the laundry product or other disinfecting procedures. ■

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MAINTENANCE AND OPERATION

Conductive Terrazzo Flooring Needs Care From the Start To Ensure a Good Finish

TERRAZZO flooring – a favorite choice for anesthetizing locations because of its excellent conductive properties – is only as good as its maintenance.

The fact that a floor meets recommended standards at the time of installation is no assurance that it will do so in the future unless proper maintenance methods are used.

For routine cleaning, many firms have developed special cleaners that make daily cleaning no problem. Most important, under no circumstance should wax be applied to any conductive floor, since it acts as an insulator. Terrazzo, of course, does not require waxing to maintain its appearance.

When problems of maintenance occur, it is frequently because either supervisory personnel is buying inferior cleaning materials to effect slight savings, or janitorial personnel is using improper technics or materials. The worst situation is where inferior materials are being used by careless workers.

It has been proved that terrazzo maintenance costs are generally 95 per cent labor and only 5 per cent materials. Thus, cutting corners on maintenance materials provides, at best, a negligible saving, while causing future maintenance problems.

The personnel problem is admittedly a serious one for the hospital administrator, but proper maintenance methods can result only from proper supervision.

For example, in several hospitals fairly new conductive terrazzo floors were found in astonishingly bad condition as a result of personnel using surgeons' hand soap or other equally unsuitable – and expensive – materials to clean the floors.

Where such abuse has extended over a considerable period, conductive terrazzo, or for that matter any conductive flooring, gradually loses its conductivity through accretion of dirt and gummy material. A comparable situation would be to place a rug on a conductive floor. The buildup of material on the floor interposes a nonconductive material between personnel, objects and the floor – always a dangerous situation.

If the floor does not respond to recommended cleaners, the next step is to apply a calcium chloride solution, using a proportion of 0.6 of an ounce of calcium chloride to 3.5 ounces of water for every square foot of floor area to be treated. The floor should be allowed to dry thoroughly for 24 hours preceding application. The solution is simply poured on the floors, spread with a mop, and allowed to be absorbed into the floor.

In cases where buildup has been heavy, the terrazzo may still fail to respond to the calcium chloride treatment. In this event, the only remaining step is to regrind the floor, taking one-sixteenth of an inch off the top. One day after grinding the floor should be treated with calcium chloride. Following this, the floor should be resealed and proper maintenance technics instituted immediately. – THEODORE MEDFORD, *executive secretary, National Terrazzo and Mosaic Association.* ■

Despite heavy daily traffic, proper maintenance has preserved the finish of the conductive terrazzo floor at Children's Hospital, Washington, D.C.

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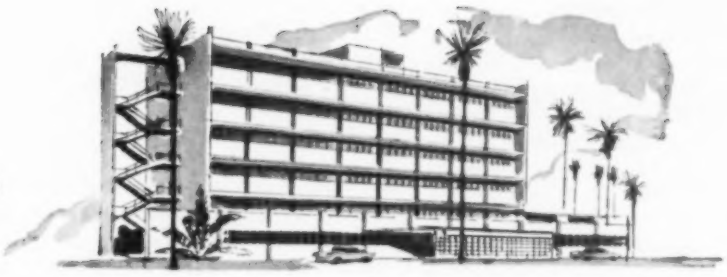

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(*Continued From Page 69*)

a suitable wage structure. The court stated that workers could quit their jobs individually. If not they would be reduced to the status of peons. Also, while they could not strike they could engage in peaceful picketing as long as this activity did not prevent persons from crossing the picket line, or otherwise materially interfere with the functioning of the hospital. The court gave little consideration to the arguments that peaceful picketing would increase the strain upon those engaged in the healing of the sick, that it would breed discontent, promote unpleasantness, and affect the patient negatively.

Ruled Against Strike

In another decision, namely, the Mount Sinai Hospital v. Davis case,[26] rendered on May 21, 1959, this state supreme court ruled again that a union doesn't have the right to strike against a voluntary nonprofit hospital on the grounds that labor's right to strike is not unlimited, and that such behavior would endanger public health and safety and be detrimental to the public interest, and the employes involved are not engaged in industry, craft, trade or occupation for profit. Therefore, an injunction to prevent the strike could be issued. However, the unions did strike and picket the nonprofit hospital and willfully disobey the injunction order restraining such behavior. The New York supreme court ruled that these labor organizations could not be held in criminal contempt of court because the injunction was invalid.[27] A labor dispute was involved and voluntary nonprofit hospitals are not exempt from the New York Anti-Injunction Act. Furthermore, the objective of the strike and the picketing was to force these hospitals to bargain or to discuss employe grievances; therefore the strike and the picketing were legal. The court reasoned that the New York constitution guaranteed to workers the right to organize and to bargain collectively through their representatives, and categorized picketing as a form of freedom of speech by labor. A motion to punish for contempt of court was denied.

However, in adjudicating this case the appellate division of the New York supreme court later ruled that union officials were legally obligated or were under duty to respect or obey the injunction orders until they were set aside by proper court procedures. Because these officials failed to obey the injunction they were guilty of criminal contempt of court and were subject to penalties involving fines and imprisonment.[28]

The Minnesota supreme court has ruled that the Minnesota State Labor Relations Act is applicable to charitable hospitals and to their maintenance and nonprofessional workers. The court reasoned that the act does not make the right to collective bargaining dependent upon the nature of the employers' operations. The hospital is an employer and the attempt to unionize involves a labor dispute. No injunction could be issued to prevent union organization of hospital employes. However, the court stated that strikes and picketing result in unrest among employes and create nervousness among the patients; therefore the employer and the union are definitely obligated to settle their troubles by arbitration as outlined in the act.[29]

In 1947 the Minnesota legislature passed a law barring strikes and lockouts in charitable hospitals because such concerted activities are against public policy. The employes and the union are restricted from participating in a strike, or encouraging and causing a work stoppage, and management cannot interfere with the hospital's function by the use of lockouts.

The law establishes a definite and comprehensive grievance procedure. Provision is made for settlement of disputes by the administrators and the employes in the hospitals involved through negotiation. The parties can use the facilities of the department of labor for conciliation. If no settlement is reached through negotiation or conciliation the law requires that a board of arbitration consisting of three be created and the decision of the board is to be final and binding. The employer is permitted to appoint one arbitrator, the union or employes appoint one, and these two arbitrators choose the third member of the board who is to act as the chairman. If the arbitrators selected by the employer and the union or the employes cannot agree upon the third arbitrator within a five-day period then the governor appoints him.[30] The law definitely states that such matters as union security and the prerogatives of management relating to the welfare of the patients are not to be subjects for arbitration. This law has been upheld by the Minnesota courts.

Some state labor relation laws do not apply to hospitals, particularly to nonprofit charitable hospitals, because these institutions are not considered to be industries. For example, a New Jersey court ruled that a hospital was entitled to an injunction to prevent picketing by a union to obtain recognition and a union contract.[31]

Upheld Hospital Exemption

In Massachusetts the supreme judicial court has ruled that the Massachusetts State Labor Relations Act cannot be applied to a nonprofit charitable hospital and its nonprofessional employes because such an institution is not functioning as a trade or an industry, and the law by implication exempts such organizations.[32] However, the Massachusetts labor relations commission did rule that the state labor relations act did cover employes of a corporation that collected money from individuals and group members and paid designated hospital service bills. The board held that such a corporation was not a charitable one even though the state exempted it from taxation and accepted it as a charitable and benevolent corporation. This board postulated that a hospital is a public charity because it actually provides service without being paid, not merely because it is not organized or operated for profit.[33]

The courts of Pennsylvania have denied the rights and privileges of the state labor relations act to employes of charitable organizations regardless of the fact that there are no provisions in the statute which exclude them. The courts have applied the law narrowly and reasoned that the legislature did not intend to include hospitals in the coverage of the law. Therefore, it has been ruled that the law applies exclusively to industrial disputes. Charitable hospitals are exempt from the statute because they are not industries and employers. Also such hospitals are closely related to the public interest, and to include them in the coverage of the labor act would cause disruptions and disputes which would en-

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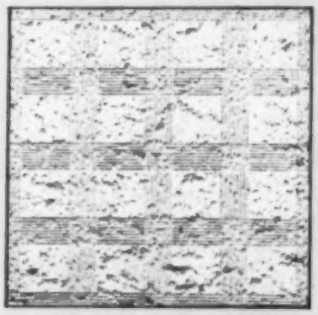

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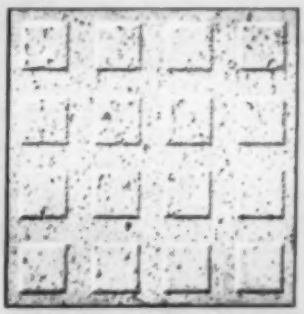

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danger public safety.[34] In a later decision the state supreme court held that the state labor relations act did not apply to charitable hospitals and their nurses because the hospitals are not engaged in interstate commerce. Such hospitals are not employers and nurses are not employes within the meaning and intent of the law; therefore the discharge of a nurse for union activities was not a labor dispute.[35]

In a very recent split decision the Colorado supreme court reversed a ruling made by the Colorado Industrial Commission, and held that the Colorado Labor Peace Act did not apply to a private charitable hospital and its nonprofessional employes because such hospitals are not industries.[36] The majority of the court accepted the point of view that the legislature did not intend the statute to include hospital employes under its coverage, even though it did not specifically exempt them. The court also reasoned that the public policy of the state was opposed to unionization, and its related concerted activities, in the area of hospital employes, largely because such behavior was detrimental to the treatment of hospital patients. The minority decision appraised the majority opinion as judicial legislation, and the usurping of power that had been legally allocated to the legislative branch of the government. ■

CITATIONS

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2. New York Hospitals 17 LRRM 1506 (1945).
3. Tennessee Coal, Iron and Railroad Co. Case No. 111-1668 D (1944).
4. United Employers, Inc. and Alameda County Nurses Association, Inc. Case No. 10 24309 (1944).
5. 50 NLRB 393 (1943).
6. American Steel and Wire Co. 58 NLRB 253 (1944).
7. Consolidated Vultee Aircraft Corp. 56 NLRB 1785 (1944).
8. NLRB *v.* Central Dispensary and Emergency Hospital 145 F2d 852 CCA DC (1944).
9. General Electric Co. (Kadlec Hospital) 89 NLRB 1247 (1950).
10. Kennecott Copper Co. 99 NLRB 748 (1952).
11. Hospital Hato Tejas, Inc. 111 NLRB 155 (1955).
12. 108 NLRB 591 (1954).
13. Flatbush General Hospital 126 NLRB No. 22 (1960).
14. Utah Board *v.* Utah Valley Hospital 235 P2d 520 (1951).
15. Local "KK," State, County and Municipal Workers of America, CIO *v.* Evangelical Deaconess Hospital No. 523 Ce-77 (1942).
16. Wisconsin Employment Relations Board *v.* Evangelical Deaconess Society of Wisconsin No. 181-264 (1942); 10 LRRM 676 (1942).
17. Wisconsin Employment Relations Board *v.* Evangelical Deaconess Society of Wisconsin No. 117, Jan. 12 (1943).
18. Wisconsin Employment Relations Board *v.* St. Francis Hospital (1959) Wisconsin Board *v.* St. Joseph's Hospital (1952).
19. Case of Dr. H. F. McChesney Case No. SE-2736 (1939) 4 LRRM 482 (1939).
20. Royal Concourse Co., Inc. and Hospital and Medical Employes 14 SLRB No. 135 (1951); 29 LRRM 1085 (1951).
21. Hunts Point Corp. 22 SLRB No. 18 (1959); 43 LRRM 1425 (1959).
22. Brunswick Home, Inc. 22 SLRB No. 41 (1959); 44 LRRM 1060 (1959).
23. N. Y. State Labor Relations Board *v.* McChesney 175 Misc. 95; 21 NYS 2d 771 (1940).
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28. Mount Sinai Hospital *v.* Davis 190 NYS 2d 126 (1959).
29. Northwestern Hospital *v.* Public Building Service, Building Employes Union Local 113 294 NW 215 (1940).
30. 20 LRRM 3013 (1947).
31. Elizabeth General Hospital and Dispensary *v.* Elizabeth General Hospital Employes, Local AA. (June 10, 1944) New Jersey Chancery Court *v.* Stein (1946).
32. St. Luke's Hospital *v.* Labor Commission Massachusetts Supreme Judicial Court (Nov. 30, 1946).
33. Massachusetts Hospital Service, Inc. 20 LRRM 1317 (1947).
34. Western Pennsylvania Hospitals *v.* Lichliter 340 Pa. 382 (1941); 17 A 2d 206 (1941).
Salvation Army *v.* Penna. Labor Relations Board 349 Pa. 105 (1944); 36 A 2d 479 (1944).
35. Penna. Board *v.* Mid-Valley Hospital Association (June 25, 1956).
36. St. Luke's Hospital *v.* Industrial Commission 45 LRRM 2953 (1960).

The Modern Hospital News Digest

Catholic Hospital Delegates Listen to Instructions on How To Listen

Although hospital employes may joke about their poor listening habits, it's no laughing matter when a life may be at stake, speakers emphasized at the Catholic Hospital Association meeting last month.

(See page 134)

Get In There and Fight for More State Funds for Indigent Care, Administrators Advised

Take off your gloves and battle the state legislature for an increase in funds for care of the indigent, one speaker urged an audience at the 1960 meeting of the Tennessee Hospital Association. ***(See page 136)***

Nursing Home Research Center Planned; Will Include Training School for Employes

The American Nursing Home Association is establishing in Washington, D.C., what it describes as the world's first nursing home research center. In addition to research in nursing home problems, the nonprofit center will include a school to train nursing home administrators and personnel, a library, a model nursing home and model facilities, and will be housed in a new building. Sen. John Sparkman (D.-Ala.) was named chairman of the center's board of advisers, which includes Rep. Thomas Curtis (R.-Mo.).

A.M.A. Reaffirms 1951 Guides on Hospital, Specialist Arrangements

MIAMI BEACH. — **Still concerned that some of its policy statements might be interpreted as "soft" on the subject of hospital-specialist arrangements, the House of Delegates of the American Medical Association last month reaffirmed the 1951 Guides for the Conduct of Physicians in Relationship With Institutions.** The Guides established A.M.A. policy declaring that "a physician should not dispose of his professional attainments or services to any hospital . . . under terms or conditions which permit the sale of the services of that physician by such agency for a fee."

Because subsequent policy statements on the subject failed specifically to proscribe the sale of physicians' services by hospitals, the House of Delegates at its December 1959 meeting reaffirmed the Guides and asserted that "all subsequent or inconsistent actions be considered superseded." At that time, the House also requested the Council on Medical Service to study all A.M.A. actions on hospital-physician relations and determine if any of them had indeed been inconsistent with the Guides.

Reporting the results of this study here last month, the Council referred to the joint A.M.A.-A.H.A. statement of 1953 and an interpretation of the Principles of Medical Ethics by the A.M.A.'s Judicial Council and found that these actions were "not inconsistent with the 1951 Guides but instead represent interpretation or efforts to clarify the Guides for practical application." The House adopted a reference committee report approving the Council's finding and adding nervously: "Lest there be any misunderstanding, your Reference Committee again recommends reaffirmation of the 1951 Guides as the policy of this Association."

While there wasn't much likelihood that A.M.A. policy on another subject, health care of the aged, could be misinterpreted, the House nevertheless considered several resolutions on the aged and, eventually, emerged

with statements on three separate aspects of the problem:

1. "Where an individual is able to provide for his own medical care (from personal resources, insurance or prepayment contracts, annuities or other income), government at any level has no role. When an individual is unable to provide for his own medical needs, the community has the primary responsibility for sharing in these costs. Where the community is unable to meet these obligations, the state has a responsibility; and only as a last resort is federal government participation warranted."

2. "The Board of Trustees is urged to initiate a nonpartisan open assembly to which all interested representative groups are invited for the purpose of developing the specifics of a sound approach to the health services and facilities needed by the aged, and thereafter the American Medical Association [should] present its findings and positive principles to the people."

3. "The American Medical Association [should] increase its educational program regarding employment of those over 65, emphasizing voluntary, gradual and individual retirement, thereby giving these individuals not only the right to work but the right to live in a free society with dignity and pride."

Acting on resolutions introduced by delegates from Texas and Missouri and the section on orthopedic surgery, the House requested the Board of Trustees to study "present policy regarding the required content and method of preparing hospital records" and suggested that such a study would assist the Joint Commission on Accreditation of Hospitals in "performing its over-all responsibilities." The resolutions proposing the study referred to the "vast amount of paperwork required of any physician who is on a hospital staff" and to "unnecessary duplications" in required record procedures.

Two of the resolutions had stipulated that the records study should be conducted by efficiency engineers or "management authorities outside the health care field," but the action of the House requested only that the Board of Trustees should undertake the study in "a manner which it deems most suitable."

Rejecting two resolutions asking the Council on Medical Education to "reevaluate the approved intern pro-

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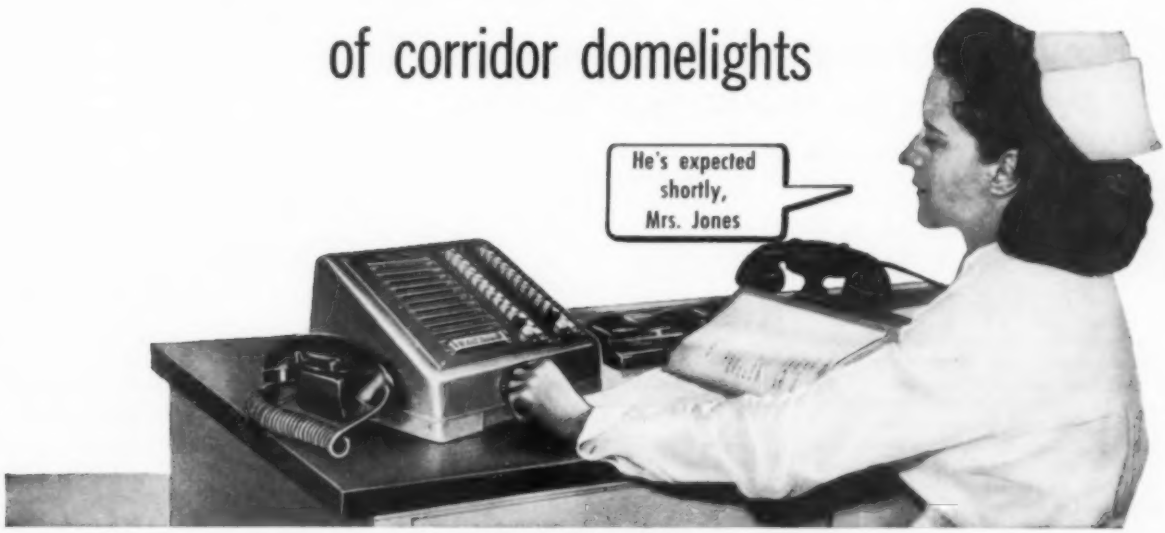

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grams so that the available supply may be more equitably spread over all approved hospitals," the House referred to reports of previous internship studies pointing out that there are more internships than interns and that some vacancies are therefore inevitable. "Any arbitrary scheme designed to allocate interns to hospitals would violate the clear right of each intern to indicate his own choice," the report said, "and any fixed formula for determining the number of interns for each hospital is unrealistic and impractical."

Iowa Assigns Students for Residency Training in Hospital Administration

IOWA CITY, IOWA. — Administrative residencies in the graduate program in hospital administration at the State University of Iowa have been assigned as follows:

Eugene W. Arnett to Milwaukee County Hospital, Milwaukee; Dana F. Bamford to Rockford Memorial Hospital, Rockford, Ill.; Keith D. Blayney to Trumbull Memorial Hospital, Warren, Ohio; James H. Cavanaugh to Princeton Hospital, Princeton, N.J.; Kenneth W. Cook Jr. to St. Luke's Hospital, St. Paul; Ronald S. Eggers to St. Luke's Methodist Hospital, Cedar Rapids, Iowa; Richard D. Green to Schoitz Memorial Hospital, Waterloo, Iowa.

Fredrich W. Hageboeck to Boulder Medical Center, Boulder, Colo.; L. Milton Holmgrain to Pekin Public Hospital, Pekin, Ill.; Howard W. Houser to Huntington Hospital, Huntington, Long Island, N.Y.; A. Warren Kegerreis Jr. to Morristown Memorial Hospital, Morristown, N.J.; Keith D. Ketelsen to Asbury Methodist Hospital, St. Louis Park, Minn.

Gary E. Larson to Emanuel Hospital, Portland, Ore.; E. Thomas Lietzke to University of Washington Hospital, Seattle; William L. Lillibridge to University of Iowa Hospitals, Iowa City; Ted R. Roberts to Veterans Administration Hospital, Iowa City; James D. M. Russell to Luther Hospital, Eau Claire, Wis., and Robert D. Schabacker to University of Iowa Hospitals, Iowa City.

Hospital Residents Named by Washington University

ST. LOUIS. — Students in hospital administration at Washington University have been assigned to the following residencies, the school has announced:

LaVaughn Boldt to Research Hospital, Kansas City, Mo.; Douglas Carpenter to Tucson Medical Center, Tucson, Ariz.; James Collom to U.S.A.F. Hospital, Scott Air Force Base, Ill.; Harry Davis to Hillcrest Memorial Center, Tulsa, Okla.; B. Joe Gunn to Arkansas Baptist Hospital, Little Rock; Arthur Full to Allen Memorial Hospital, Waterloo, Iowa.

Makonnen Habtemariam to Barnes Hospital, St. Louis (first six months), and U.S. Public Health Service, Washington, D. C., (second six months); Noel Kroncke to Lankenau Hospital, Philadelphia; Paul Masar to St. Mary Corwin Hospital, Pueblo, Colo.; William Mitchell to University of Mississippi Hospital, Jackson; Paul Nelson to Wesley Hospital, Wichita, Kan.; Robert Shakno to Veterans Administration Hospital, Houston, Tex.; Stephen K. Wilson to Orange Memorial Hospital, Orlando, Fla., and Jere Witherspoon to Memorial Mission Hospital, Asheville, N.C.

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'Learn To Listen,' Speakers Tell Audiences at Catholic Hospital Association Meeting

MILWAUKEE. — "They have ears and hear not. . . ." The psalmist's words were echoed many times by speakers at the Catholic Hospital Association meeting here May 30 to June 2, which was dedicated to the proposition that hospital management can be improved through communication.

Communications were taken apart and examined up, down and sideways by representatives of the Church, industry, hospitals, universities and the law. The consensus of all speakers was that communications generally are bad, not only in hospitals but in all areas of human relations; that "lack of adequate communications is the chief cause of most of the misunderstandings and strife that occur in hospitals," in the words of one speaker; that it is harder to communicate from the bottom up than from the top down, and that the greatest failure of all persons involved in communications is the failure to listen.

"Effective listening is an essential job skill," in the opinion of Donald E. Bird, Ph.D., associate professor of speech and communications at Stephens College, Columbia, Mo. "Because the efficient functioning of a hospital depends upon the communication ability of all persons in the hospital, listening skill is vital to the welfare of the patient," Dr. Bird stated. Listening training needs to be a part of the curriculum for doctors, nurses, dietitians and hospital administrators, he asserted. "We joke about our poor listening, but it is no joke in a world where a misunderstood oral message may trigger Armageddon, nor is it a laughing matter in hospitals where lives are in the balance," the speaker admonished his audience.

Clarity and precision in the use of language were recommended by James N. Holm, Ph.D., professor of speech at Kent State University, Kent, Ohio, who termed language "at once an indispensable yet a treacherous implement." He offered three basic principles in the use of language that should help people in their communications with one another:

"1. *Words* do not mean; *people* do. The meaning does not exist in the word, but in the intention of the communicator.

"2. In all communication, description comes first, prescription later. Talk about facts first.

"3. Language is limited; reality is infinite. Our words too frequently do not denote a vital reality, hence our talk may become meaningless."

During the meeting, which was attended by an estimated 4500 persons, the Rt. Rev. Msgr. A. W. Jess, Camden, N.J., took over the duties of president from Father John J. Humensky, Cleveland.

Other new officers elected at the meeting are: President-elect, the Very Rev. Msgr. Clement G. Schindler, Belleville, Ill.; first vice president, Very Rev. Msgr. William J. Monahan, Denver, and second vice president, the Rev. James H. Fitzpatrick, Brooklyn, N.Y. Named to the association's executive board were: Sister M. Christine, C.C.V.I., St. Joseph's Hospital, Houston, and Sister John Joseph, C.S.J., of Santa Rosa Hospital, Santa Rosa, Calif.

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Administrators Must Battle Legislature for Funds, Tennessee Speaker Advises

MEMPHIS, TENN. — Administrators should stop "pussy-footing" around and start pressuring the state legislature for funds, they were told at the Tennessee Hospital Association meeting here May 26.

Edward H. Stohler, administrator of Memorial Hospital, Johnson City, advised the administrators to "take off their gloves" for the battle to obtain more funds.

Among the recommendations the association will ask the legislature to approve, Mr. Stohler said, are:

1. An increase in funds for the care of the indigent.
2. An increase in appropriations for the welfare recipient hospitalization program.
3. Approval of state-county matching funds to provide outpatient services for the aged and to encourage the establishment of special clinics for the aged.

Mr. Stohler urged hospital administrators to work with their state legislatures in explaining the economics of hospital care for indigents.

Frank S. Groner, president-elect of the American Hospital Association, in his address, deplored the fact that hospitals are being forced to pass on to the paying patient the cost of the indigent, education, research and other expenses that are not adequately financed.

He also discussed reorganization of Blue Cross and warned: "If Blue Cross should disappear, government control would be inevitable."

James E. Ferguson, administrator of University of Tennessee Memorial Research Center and Hospital, Knoxville, was named president-elect of the association.

Dr. Richard Cannon, director of Vanderbilt University Hospital, Nashville, was elected president succeeding Frank Magoffin, business administrator of Oakville Memorial Sanatorium, Memphis. Harold L. Peterson, administrator of Baroness Erlanger Hospital, Chattanooga, had resigned as president-elect. He is on a leave of absence to serve as a hospital consultant in Venezeula.

Other new officers are: first vice president, E. A. Herron, administrator of Blount Memorial Hospital, Maryville; second vice president, Adalbert Dierks, administrator of Le Bonheur Children's Hospital, Memphis, and treasurer, C. L. Gardner, administrator of Williamson County Hospital, Franklin.

Conference To Consider Medical Audit Procedures

DENVER. — Doctors and hospital administrators interested in learning more about medical audit procedures will have an opportunity to do so by attending a conference here devoted to this subject.

The conference, which will be held August 10, 11 and 12, will include discussions by guest speakers who are closely associated with the mechanics of medical audit programs.

Planners of the conference are: Dr. Vergil Slee, director of the Commission on Professional and Hospital Activities; Dr. Robert S. Myers, treasurer of the Commission, and Dr. C. Wesley Eisele, assistant dean in charge of postgraduate medical education at the University of Colorado Medical Center.

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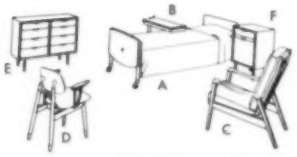

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Maine Hospitals Consider Hiring Full-Time Executive But Postpone Decision

ROCKLAND, ME. — Raymond Walton, administrator of Gardiner General Hospital, Gardiner, was named president-elect of the Maine Hospital Association at the association's annual meeting here June 8.

Mr. Walton will succeed Merrill E. Tolman, Rumford Community Hospital, Rumford, who became president during the meeting. Dolnar H. Littlefield, Augusta General Hospital, Augusta, was the retiring president.

Maine is one of the 10 remaining states without a full-time hospital association executive, Jack W. Owen, secretary of the American Hospital Association's council on association services, said at a special meeting held to discuss a recommendation to reorganize the association.

Other states without full-time executives are Vermont, New Hampshire, Nevada, Arizona, Wyoming, Alaska, Oregon, South Dakota, and Virginia, Mr. Owen said. Three states (North Dakota, Wisconsin and Indiana) have initiated full-time programs since the first of this year, he added.

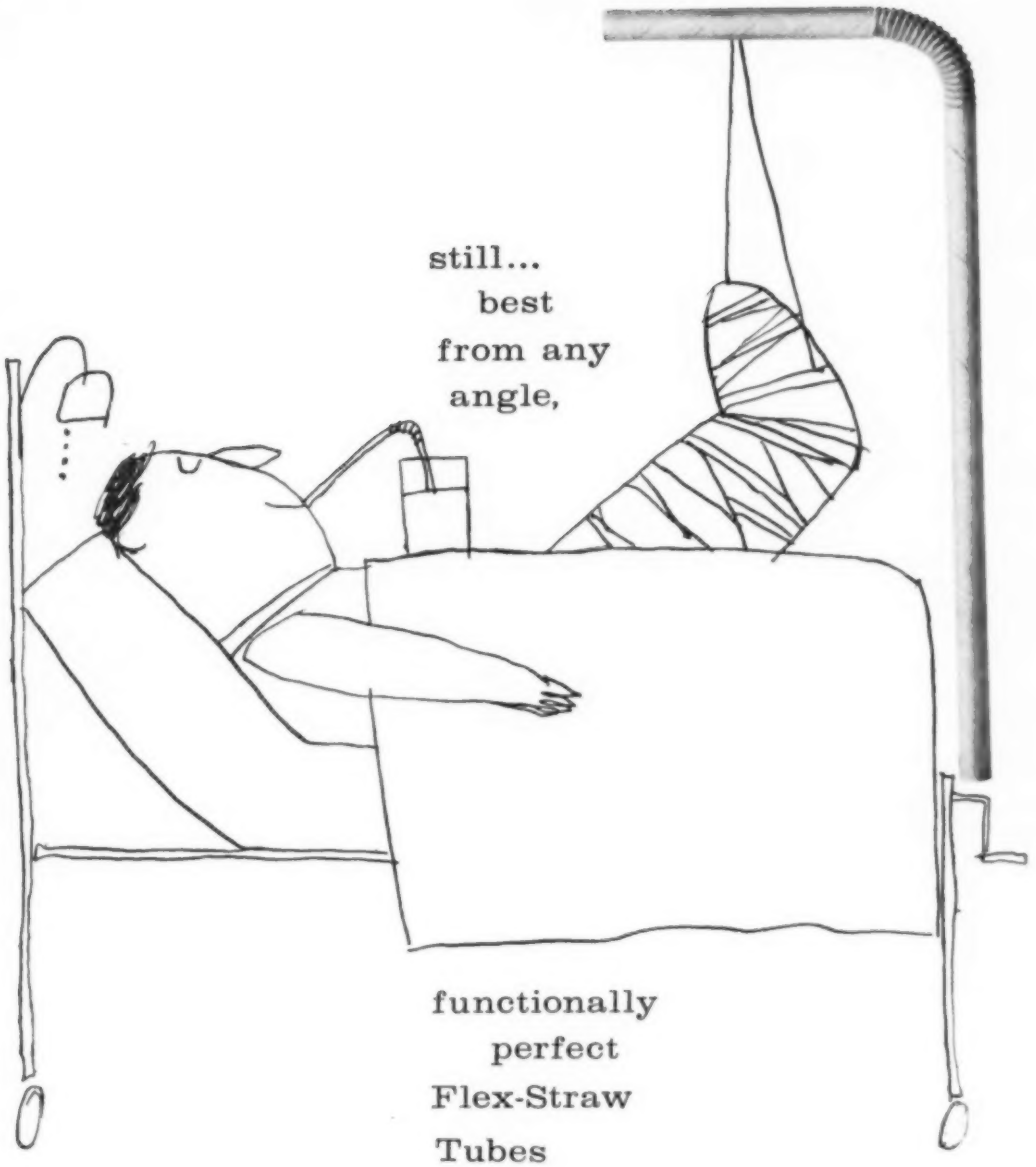
The four principal areas of activity of a full-time hospital association executive listed by Mr. Owen were:

1. Representation of hospitals in government, professional and voluntary groups.
2. Education programs for hospital personnel.
3. Investigation and fact-finding in connection with hospital problems.
4. Public relations.

Following Mr. Owen's presentation the group discussed advisability of inaugurating a full-time program but postponed any decision when it developed that changes in the by-laws and dues structure would be necessary.

Eleanor Lambertsen, assistant secretary of the council on professional practice, American Hospital Association, discussed problems of nursing service and nursing education. She described the present structure of nursing service as "patchwork" and called on hospitals to develop better comunications with nurse executives.

Sister Mary Mercy, Mercy Hospital, Portland, was reelected secretary of the association, and Roland Chabot, director of accounts at St. Mary's General Hospital, Lewiston, was elected treasurer.



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Northwestern Lists Posts for Residency Training

CHICAGO.—Assignment of students to hospital administration residencies have been announced by Northwestern University School of Business as follows:

Gene R. Barron to Grant Hospital, Chicago; 1st Lt. James O. Bowen, MSC, to MacDill Air Force Base, Tampa, Fla.; Melvin L. Clothier to Bishop Clarkson Memorial Hospital, Omaha; Charles S. Fox to Harrisburg Polyclinic Hospital, Harrisburg, Pa.; Ronald C. Harm to Herrick Memorial Hospital, Berkeley, Calif.; George L. Heidkamp to MacNeal Memorial Hospital, Berwyn, Ill.

John P. Hyden to Norwegian-American Hospital, Chicago; Carl G. Jaeger to Passavant Memorial Hospital, Chicago; Paul M. Jarchow to Veterans Administration Research Hospital, Chicago; Perry T. Jones to Watts Hospital, Durham, N.C.; Harold E. Josehart to Butterworth Hospital, Grand Rapids, Mich.; 1st Lt. Donn R. Kelsey, MSC, to Chanute Air Force Hospital, Rantoul, Ill.

Kenzo Kiikuni to Edgewater Hospital, Chicago; Donald A. Lacey to Perth Amboy General Hospital, Perth Amboy, N.J.; B. Parnell Langston to University Hospital and Hillman Clinics, Birmingham, Ala.; Donald K. Larson to Passavant Memorial Hospital, Chicago; Wesley Ginn to Bellin Memorial Hospital, Green Bay, Wis.; John H. Luff to Welborn Baptist Hospital, Evansville, Ind.

J. Frank Meisamer to West Tennessee Tuberculosis Hospital, Memphis; Marvin F. Neely Jr. to Louisville Medical Center, Louisville, Ky.; Victor T. O'Neal to Newton-Wellesley Hospital, Newton Lower Falls, Mass.; Charles G. Pierson to Chicago Wesley Memorial Hospital, Chicago; Theodore S. Proud to Norwegian-American Hospital, Chicago; John S. Shipps to Fairview Park Hospital, Cleveland; Sarah M. Smith to Methodist Hospital, Indianapolis.

Donald W. Snyder to White Cross Hospital, Columbus, Ohio; Lowell J. Spirer to Mount Sinai Hospital, Milwaukee; Richard Thomas to Ravenswood Hospital, Chicago; Maximo Villacorta to St. Mary of Nazareth Hospital, Chicago; Max L. Wahlman to Veterans Administration Hospital, Houston; Ervin H. Weber to Milwaukee County General Hospital, Milwaukee, and Barry J. Widen to Maimonides Hospital, Brooklyn, N.Y.

Student Residents Named by University of Michigan

ANN ARBOR, MICH.—The University of Michigan has announced the following residency appointments for students in hospital administration:

John H. Bergman to Aultman Hospital, Canton, Ohio; John C. Booth to Peninsula Hospital, Burlingame, Calif.; Alan R. Case to Parkview Memorial Hospital, Fort Wayne, Ind.; Thomas B. Coles Jr. to Grace Hospital, Detroit; Gordon M. Derzon to Brooklyn Hospital, Brooklyn, N.Y.

William J. Downer Jr. to Blodgett Memorial Hospital, Grand Rapids, Mich.; James P. Fitzgerald to William Beaumont Hospital, Royal Oak, Mich.; David M. Hunter to Harper Hospital, Detroit; Sister Mary Marcia to St. Joseph's Hospital, Ann Arbor, Mich., (first period) and St. Mary's Hospital, Grand Rapids, Mich.

John C. Newton to Johns Hopkins Hospital, Baltimore; Gerard F. Odenweller to Detroit Memorial Hospital, Detroit; Robert W. Spencer to University Hospital, Ann Arbor, Mich.; Hubert D. Sycamore to New England Deaconess Hospital, Boston; James S. Urda to Delaware Hospital, Wilmington, and Clive R. Waxman Jr. to Children's Hospital, Detroit.

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Sonic Energy Systems

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Division of AMERICAN STERILIZER COMPANY, Erie, Pa.

World's largest designer and manufacturer of Sterilizers, Surgical Tables, Lights and related technical equipment

Yale Announces Posts for Administration Students

NEW HAVEN, CONN. — Hospitals to which students in hospital administration have been assigned for residencies have been announced by Yale University Department of Public Health. The assignments are:

Gordon R. Beem to U.S.A.F. Hospital, Maxwell Air Force Base, Ala.; Benjamin L. Capili to Stamford Hospital, Stamford, Conn.; Alfred E. Fletcher to Grace-New Haven Community Hospital, New Haven, Conn.; George I. Glover to Geisinger Memorial Hospital, Danville, Pa.; Edward A. Janasz to Memorial Hospital, Worchester, Mass.; Dr. Saeed T. Motameni to Ministry of Health, Iran.

Joseph T. Prekup to Massachusetts General Hospital (McLean Hospital), Belmont, Mass.; Herbert Rubinstein to Lynn Hospital, Lynn, Mass.; William R. Slivka to U.S.A.F. Hospital, Carswell, Fort Worth, Tex.; G. Pierce Taylor to Woonsocket Hospital, Woonsocket, R.I.; Raymond C. Walker to Massachusetts General Hospital, Boston, and Harold W. Wicks to New England Center Hospital, Boston.

California Announces Residency Appointments

BERKELEY.—The University of California's course in hospital administration has announced the following residencies:

Thomas J. Andrews to San Diego County Hospital, San Diego, Calif.; Daniel M. Anzel to University of California Medical Center, San Francisco; Ronald J. Davey to Sharp Memorial Hospital, San Diego, Calif.; Michael S. Diener to Cedars of Lebanon Hospital, Los Angeles; Ronald W. Harper to California Hospital, Los Angeles, and Dane M. Long to Mount Zion Hospital, San Francisco.

Herbert M. Ormsby to St. Francis Hospital, San Francisco; Boone Powell Jr. to Baptist Memorial Hospital, Memphis, Tenn.; Capt. Ray M. Teems to U.S.A.F. Hospital, Keesler Air Force Base, Miss.; Frederick A. Traill to Baylor University Medical Center, Dallas, and Joan Turnquist to Fresno Community Hospital, Fresno, Calif.

Marjorie Saunders Wins Public Relations Award

WHITE SULPHUR SPRINGS, W. VA. — Recognition for outstanding public relations in the hospital field has been given to Marjorie Saunders, director of public relations at Baylor Medical Center, Dallas.

Miss Saunders was presented one of 19 Silver Anvil awards by the American Public Relations Association at its meeting here. Only one award was presented in each category. Miss Saunders was honored, the association announced, for her work in connection with the opening of the hospital's women's and children's section last fall.

Film on Hospital Sepsis Receives National Award

NEW BRUNSWICK, N. J. — National recognition has been given to the film "Hospital Sepsis: A Communicable Disease" by the American Film Festival.

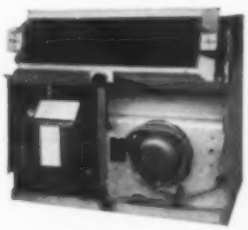
The film received the national medical film award for professional audiences. The film was sponsored by the American Medical Association, the American College of Surgeons, and the American Hospital Association under a grant by Johnson & Johnson.

THE NEW CONCEPT IN HEATING AND COOLING

ELIMINATES THE COSTLY "CENTRAL SYSTEM"

Other year-round air-conditioners *still* require elaborate central systems for the cooling cycle. Now, the new Warren Webster concept in heating and cooling obsoletes this costly installation for hospital management: each Webster Newport is a *self-contained* unit for both heating *and* cooling. Comfort control is at your fingertips—day or night, summer or winter. Simply turn the knob of a Webster Newport for heating or cooling at *any* time, as patients' varying needs may require. Heat one room or ward while you cool another . . . *every* area equipped with a Newport has its own individual system for year-round heating and cooling.

This modern way to air-condition saves you money right from the start. Attractive in-wall units can be installed a room at a time, as budget allocations permit —and *without* interruption of hospital services. Webster Newports connect readily to existing heating systems—or a new all-electric model will tie in with electrical circuiting. The entire hospital can be air-conditioned in easy stages at savings up to 30% as compared to a central system installation. Let a Warren Webster man detail the savings—and convenience—*you* can look for with Webster Newport heating and cooling.



COOLING BY CHRYSLER AIRTEMP

EQUIPPED WITH CHRYSLER'S HEAVY-DUTY COMMERCIAL COOLING CHASSIS

WARREN WEBSTER & COMPANY, INC.

HEATING • COOLING

CAMDEN 5, NEW JERSEY

Photo by Parke Randall, The *Indianapolis News*.

Collapse of this temporary scaffold killed two persons and injured approximately 90, thus signaling the start of hospital emergency.

Hospital Emergency Plan Meets Speedway Disaster Head On

Planning and practice had prepared Methodist Hospital to care for the victims of the tragic Memorial Day accident at Indianapolis

INDIANAPOLIS. — Hospitals here have often felt that if they were called upon to serve a large number of emergency patients at a time, it might be on Memorial Day when more than 200,000 persons gather at the Indianapolis Speedway. Methodist Hospital has always felt a special responsibility in this regard because it furnishes the majority of the medical and nursing staff for the track hospital and because all track accidents have been directed to Methodist in recent years.

It was not entirely coincidence, therefore, that Methodist Hospital carried out a mock disaster drill on May 23, just seven days before more than 50 patients were received in the hospital emergency ward from an accident at the Speedway.

Collapse of an infield scaffolding killed two persons instantly and injured approximately 90. After preliminary screening at the scene of the accident, the injured were given emergency treatment and were further screened at the Speedway's temporary hospital.

The track hospital immediately notified Methodist that it would receive many seriously injured patients within a short time. The chief surgery resident then informed the hospital telephone office and nursing administration and asked that the disaster plan be put into effect. All departments immediately started assembling off-duty personnel.

As a large number of the hospital house staff was assigned to the Speedway for the day, and many of the attending staff were at the race, both professionally and for recreation, we feared that there would be an inadequate number of physicians available. Therefore, in addition to calls by the hospital telephone operators, announcements were made on local radio stations requesting Methodist Hospital physicians to report to the hospital. More than 25 reported directly and numerous others called in.

In the meantime, screening of patients by the medical and nursing staff at the Speedway hospital had been completed, and those in most serious condition were placed in ambulances. Patients in severe pain were administered morphine at the track hospital, and a red lipstick mark was made on the patient's forehead for designation. This later proved somewhat of

a problem as the lipstick melted and was absorbed in the sunburn of many of the patients.

In the practice drill, one of the problems disclosed was an inadequate number of carts available at the emergency room. All hospital carts and wheel chairs, therefore, were sent to the corridor adjacent to the receiving room to be available when the ambulances arrived. All available male employes were recruited as orderlies.

The admission office was notified to stop the admission of elective patients until we could determine how many emergency patients would be admitted.

The practice drill had made apparent to hospital personnel some of the basic problems to be faced. Only a few patients were treated in the five treatment rooms of the emergency department. The rest were sorted and forwarded to other areas in accordance with the plan.

With an adequate number of medical and nursing personnel assigned to the receiving room area there was never a jam, although more than 50 patients were received in approximately a 40 minute period.

The disaster plan "Emergency Treatment Tag" was attached in the receiving area. The senior surgical resident forwarded the patient to the next location and assigned the patient, if possible, to a member of the attending staff for further treatment.

All protocol was abolished. The surgical resident assumed authority and assigned patients in accordance with his own best judgment. Contrary to the plan, the house staff took charge in the emergency room area. This proved practical and was not questioned by the senior attending staff because the house doctors were most familiar with the equipment, supplies and procedures in this area. The disaster plan has since been amended to make this change.

The outpatient department, located on the floor immediately above the emergency department, was set up as the minor surgery to replace the emergency room service. More than 25 patients were treated there during the 2½ hours this department was in operation.

Housekeeping porters were assigned to the self-operating elevators to see that only emergency patients were allowed to use them; therefore, there was no elevator blockage. The only problem occurred in handling a patient with a broken back who had been placed on a board by the Speedway hospital. The board did not fit into the elevator, and we had to call a maintenance man to saw off the end of the board before the patient could be transferred to the shock room and surgery.

Methodist Hospital had opened its new 22 bed postanesthesia recovery room a month prior to the disaster. We had decided that this would serve as a shock room. Patients who appeared in extremely serious condition were transported immediately to this area from the emergency room unless it was felt essential that an x-ray be taken first. The recovery room was divided into two sections. One was used for shock patients; the other was reserved for postoperative patients. This worked out extremely well and proved its worth when a relatively large number of patients returned from surgery, giving proper differentiation between the types of patients.

In addition to nursing personnel, an attending staff surgeon, two resident physicians, and an intern were assigned to the recovery area to watch patients. As these patients had no previous orders for their treatment, this was essential.

The accident was primarily orthopedic in nature. This meant that x-ray played an important role, with the majority of patients sent to the x-ray department for examination.

Although the disaster plan provided for nursing care for patients in the x-ray department to be supplied from the adjacent nursing unit, this was required to a far greater degree than anticipated. At times there were 25 seriously ill patients in the department on carts or in wheel chairs awaiting x-ray examinations or final diagnosis from the film. We had to set up a nursing substation in the department for careful observation for shock. Approximately eight members of the nursing staff were assigned to the x-ray department and a resident physician assumed responsibility for making medical decisions, writing orders, and further assigning patients.

X-ray technicians arrived en masse shortly after the patients, and processing was soon moving rapidly. It was important that a radiologist was present. The technician on duty had the foresight to warm up immediately the automatic processing developing machine. This proved its worth more than at any time since its installation 18 months previously. Films were developed and interpreted in minutes in a truly assembly-line procedure.

A large auditorium adjacent to the main building was set up as the information center. Two hospital administrative officers were assigned to this area. Although reporters were on the scene immediately, it was some time before families started to come in or call. Calls were possibly limited in number because many of the victims were from out of the immediate locality.

At the same time, hospital representatives were somewhat handicapped by lack of early information. A log was kept of all patients, with name, address, age, injury and general condition as they were sorted from the receiving room. This was forwarded at intervals to the information center. It was necessary, however, to send a runner to the hospital many times to check on individual patients or to see if a patient by a certain name could be located. Many were false requests, but the number of patients was so large it was felt essential to check on every question. The runner also obtained increasing information on degree of injury, condition and eventual hospital admission.

Handwriting on the disaster tags was often poor and there was occasional misspelling of names which at times resulted in misidentification.

Discharged patients were sent to the information center for transportation home. The center also cared for children of patients who had to wait until someone else arrived to pick them up.

Because of the importance of the practice drill the week before, I feel that such sessions will become a regular part of our program.

We are proud of the fact that of the many critically injured persons, none have died since the accident. This is some measure of the efficiency of the disaster operation. — JACK A. L. HAHN, *executive director, Methodist Hospital of Indiana, Inc., Indianapolis.*

COMING EVENTS

AMERICAN ASSOCIATION OF BLOOD BANKS, Jack Tar Hotel, San Francisco, Aug. 21-26.

AMERICAN ASSOCIATION FOR HOSPITAL CONSULTANTS, Fairmont Hotel, San Francisco, Aug. 27.

AMERICAN ASSOCIATION FOR HOSPITAL PLANNING, Federal Building and Clift Hotel, San Francisco, Aug. 26, 27.

AMERICAN ASSOCIATION OF MEDICAL CLINICS, Roosevelt Hotel, New Orleans, Oct. 6-8.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Olympia Hotel, Seattle, Oct. 10-13.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Civic Auditorium and Sheraton-Palace, San Francisco, Aug. 29-Sept. 1.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Annual Convocation, Civic Auditorium and Jack Tar Hotel, San Francisco, Aug. 27-29.

AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS, Statler-Hilton Hotel, Dallas, Oct. 30.

AMERICAN COLLEGE OF SURGEONS, Clinical Congress, San Francisco, Oct. 10-14.

AMERICAN DENTAL ASSOCIATION, Statler-Hilton Hotel, Los Angeles, Oct. 17-20.

AMERICAN DIETETIC ASSOCIATION, Sheraton Hotel, Cleveland, Oct. 18-21.

AMERICAN HOSPITAL ASSOCIATION, San Francisco, Aug. 29-Sept. 1.

AMERICAN NURSING HOME ASSOCIATION, Mayflower Hotel, Washington, D.C., Oct. 18-21.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Statler-Hilton Hotel, Los Angeles, Nov. 11-18.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, Oct. 31-Nov. 3.

AMERICAN PHARMACEUTICAL ASSOCIATION, Shoreham and Sheraton-Park hotels, Washington, D.C., Aug. 14-19.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS, Statler Hotel, New York, Oct. 2-7.

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS, Palmer House, Chicago, Sept. 27-30.

AMERICAN SOCIETY OF HOSPITAL PHARMACISTS, Shoreham and Sheraton-Park hotels, Washington, D.C., Aug. 14-19.

ASSOCIATED HOSPITALS OF MANITOBA, Royal Alexandra Hotel, Winnipeg, Oct. 25-27.

CALIFORNIA HOSPITAL ASSOCIATION, Miramar and Biltmore hotels, Santa Barbara, Oct. 24-28.

COLLEGE OF AMERICAN PATHOLOGISTS, Palmer House, Chicago, Sept. 24-27.

COLORADO HOSPITAL ASSOCIATION, Stanley Hotel, Estes Park, Sept. 18-20.

IDAHO HOSPITAL ASSOCIATION, Elk's Lodge, Boise, Oct. 17, 18.

KANSAS HOSPITAL ASSOCIATION, Broadview Hotel, Wichita, Nov. 10, 11.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Oct. 12-14.

MISSOURI HOSPITAL ASSOCIATION, Hotel President, Kansas City, Nov. 16-18.

MONTANA HOSPITAL ASSOCIATION, Florence Hotel, Missoula, Sept. 12, 13.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, Denver-Hilton Hotel, Denver, Nov. 16-19.

NATIONAL ASSOCIATION OF BOARDS OF PHARMACY, Shoreham and Sheraton-Park Hotels, Washington, D.C., Sept. 15-19.

NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, Cole Hotel, Albuquerque, N.M., Oct. 10-14.

NEBRASKA HOSPITAL ASSOCIATION, Sheraton-Fontenelle Hotel, Omaha, Oct. 20, 21.

OKLAHOMA HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 3, 4.

(*Continued on Page* 150)

with SBT-12 hospital linens fight STAPH all day!

easy to use and economical

For bacteriostatic linens and blankets. The easy addition of SBT-12* to the final rinse water of hospital laundry effectively inhibits **Staphylococcus aureus** and other odor- and disease-producing organisms. SBT-12 is economical because it is effective at low concentrations.

SBT-12 compatible with common laundry ingredients. If no final rinse is used, SBT-12 can safely be added to the detergent solution with equally good results. It is effective in the presence of ordinary laundry supplies such as softeners, bleaches, blueing, sours, and starches.

SBT-12 retains full potency in the presence of body fluids. Institutional field tests confirm the effectiveness of SBT-12 in the presence of blood serum and exudates (saliva, perspiration, urine, pus).

At higher concentrations SBT-12 actually destroys on contact antibiotic resistant staphylococci and other bacteria—a desirable feature for surgical linens. It insures a long-lasting finish that continues to destroy these pathogens while the linen is in use, even after autoclaving.

*For cottons: 4.5 - 8 fluid ounces SBT-12 per 100 lbs. dry load
For blankets: 20 - 36 fluid ounces SBT-12 per 100 lbs. dry load

The following photographs demonstrate the highly effective bacteriostatic properties of laundry treated with SBT-12.

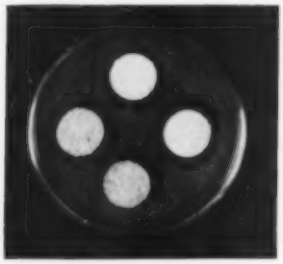


Fig. 1. Bacteriostatic activity of linens and wool blankets treated with varying amounts of SBT-12 in final rinse of laundry cycle. Test organism – **Staphylococcus aureus.** Reading clockwise from the top, fabrics were treated as follows:
1) 4.5 oz. SBT-12 per 100 lbs. linens
2) 8.0 oz. SBT-12 per 100 lbs. linens
3) 20.0 oz. SBT-12 per 100 lbs. blankets
4) 36.0 oz. SBT-12 per 100 lbs. blankets

Fig. 2a. The SBT-12 treated fabric inhibits growth of bacteria, as shown by absence of colonies (100x).

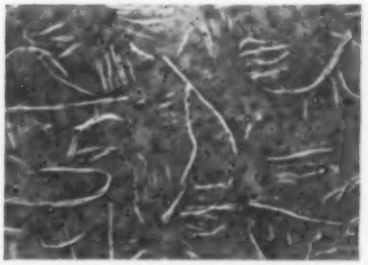


Fig. 2b. The untreated fabric allows bacterial growth, as shown by presence of colonies (100x).

The streaks visible in both figures are caused by contact of the swatch fibers with the agar.

No development of resistance to SBT-12. The action of SBT-12 is not specific against staphylococci which may explain why no resistant strains develop.

SBT-12: highly potent yet kind to fabrics. Stable and nonmetallic, SBT-12 has no adverse effect on color, hand or texture of treated fabric.

SBT-12 is also available in one pound aerosol can for use in operating rooms, bedrooms and other sepsis-breeding areas.

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For additional information, use postcard facing back cover.

Give PANHEPRIN® initially

(Heparin Sodium, Abbott)

for immediate control of coagulation

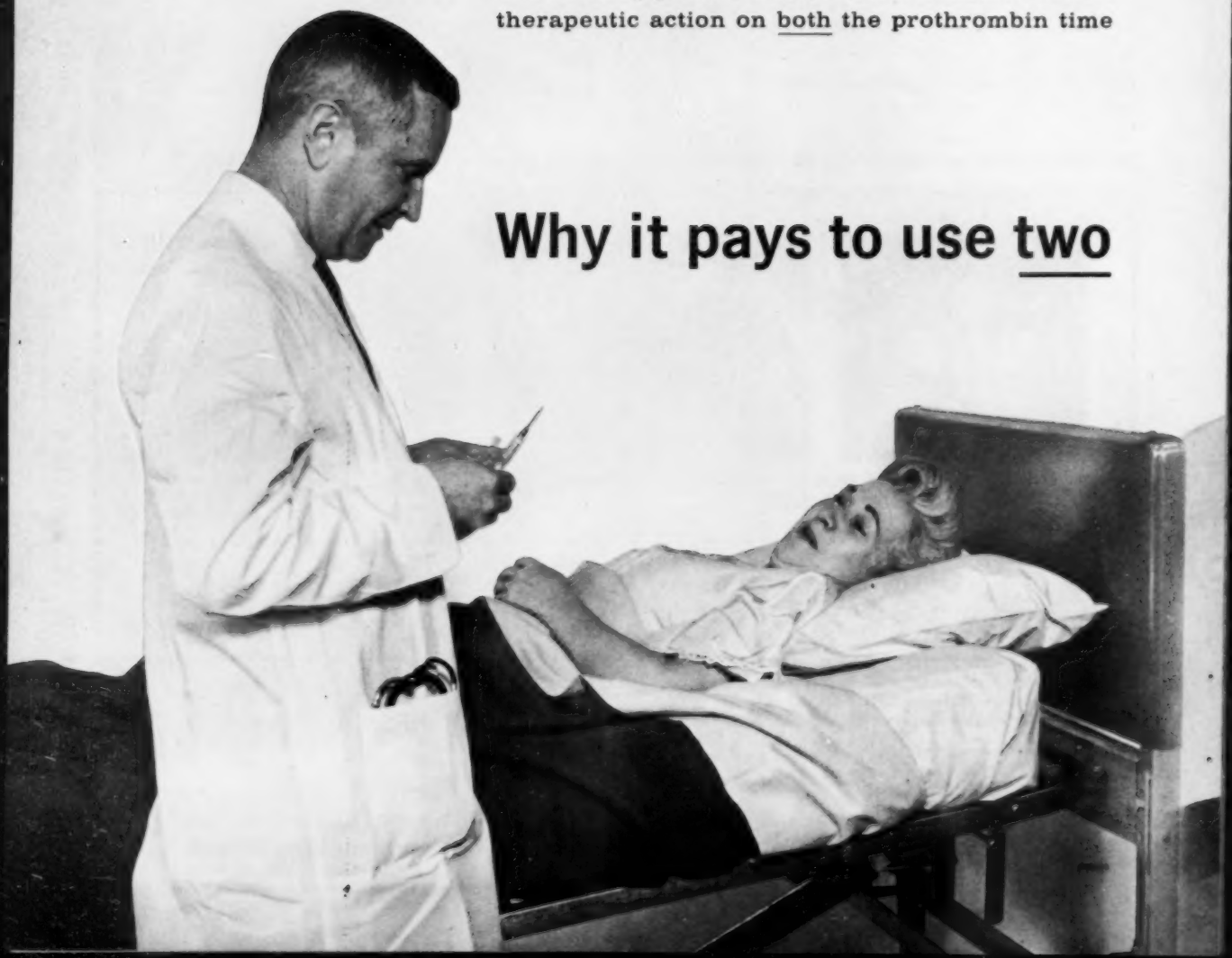
Combined treatment with heparin and a coumarin-like drug has been called "the closest approach to ideal anticoagulant therapy."[1] Parenteral and oral routes are used simultaneously. Here's how it works:

Start thrombosis and embolism patients on PANHEPRIN, given subcutaneously or intravenously. In this way you'll be using the agent of choice for rapid reduction of coagulability. It gives your patients immediate protection.

At the same time, start PANWARFIN orally. This coumarin-type agent will begin providing therapeutic prothrombin levels within 18 to 36 hours.

Both drugs may be continued for about ten days. The build-up period enables PANWARFIN to exert therapeutic action on both the prothrombin time

Why it pays to use two



Give **PANWARFIN**™ follow-up

(Warfarin Sodium, Abbott)

for predictable, low-cost oral maintenance

and the clotting time.

Thereafter, only oral PANWARFIN need be given. You'll find that maintenance is relatively easy, because PANWARFIN is predictable in effect. There's little daily variation in prothrombin times, and little juggling of dosage becomes necessary.

This combined therapy lets you provide maximum protection at the outset. Then it lets you shift to oral maintenance, to obtain added patient comfort and lower cost.

Abbott is the only company to offer you both heparin and warfarin products. Our literature gives full details on their combined and individual use. Ask your Abbott man for literature and information, or write us at North Chicago, Illinois.

1. Drugs of Choice 1960-1961 (Modell, W., Ed.); C. V. Mosby Co., St. Louis, 1960; p. 652.

At the physician's discretion, both products are often used singly. PANHEPRIN is suitable for both anticoagulant and lipemia clearing purposes, and is supplied in a handy disposable syringe (as well as vials and ampoules in concentrations from 1000 to 40,000 USP units/ml.) that makes even self-administration by the patient easy. And PANWARFIN, supplied in 5-, 10- and 25-mg. grooved tablets, may be prescribed alone for cases without urgency (e.g., chronic thrombophlebitis).

ABBOTT

anticoagulants at once

(*Continued From Page* 146)

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 24-26.

OREGON ASSOCIATION OF HOSPITALS, Gearhart Hotel, Gearhart, Oct. 16-18.

RHODE ISLAND HOSPITAL ASSOCIATION, Sheraton-Biltmore Hotel, Providence, Oct. 4.

SASKATCHEWAN HOSPITAL ASSOCIATION, Bessborough Hotel, Saskatoon, Oct. 12-14.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Masonic Temple, Mitchell, Oct. 25, 26.

WASHINGTON STATE HOSPITAL ASSOCIATION, Davenport Hotel, Spokane, Oct. 19, 20.

WEST VIRGINIA HOSPITAL ASSOCIATION, White Sulphur Springs, Sept. 22-24.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Nov. 10, 11.

Eisenhower Plan May Cost $5 Billion, Professor Says

ANN ARBOR, MICH. — **The American taxpayer might have to pay as much as $5 billion in general tax revenues by 1970 for health insurance for the aged, if President Eisenhower's proposal is adopted.**

This estimate by Professor Wilbur J. Cohen of the University of Michigan School of Social Work is based on a 10 per cent annual rise in hospital costs and 100 per cent participation in the program by those 65 and over.

(Administration experts have placed the immediate cost at $1.2 billion, assuming 80 per cent participation by 1964.)

Prof. Cohen, former director of research and statistics for social security, says it's "misleading" to think the Administration plan is low in cost, broad in benefits, and sound from a fiscal standpoint. In general, he maintains, its objectives and costs are "vague and ambiguous."

By providing that states should finance half the benefits, he said, the proposal encourages them to seek "the lowest common denominator" of benefits.

Cost Service Elects

BALTIMORE. — Newly elected officers of Hospital Cost Analysis Service, Inc., are: president, Donald F. Hagner; vice president, L. V. Hershey; secretary, A. L. Penniman Jr., and treasurer, Morton K. Blaustein.

AT CHICAGO WESLEY MEMORIAL—

12 SCOTSMAN ICE MACHINES

Save Steps, Save Labor, Cut Costs!

Nurse aide easily scoops out flaked ice from waist high bin of Scotsman Super Flaker ice machine. Note compact size.

Almost every floor at Chicago Wesley Memorial Hospital is equipped with a modern Scotsman ice machine!

In this up-to-date 700 bed hospital, 12 Scotsman ice machines solve many problems. Formerly, the hospital had its own central "ice house" where ice was frozen and shaved. Now Scotsman Flakers and Cubers provide a dependable "every floor" source for crystal clear, pure ice. There is no danger of contamination—ice does not have to be touched by hand! Waste of ice supplies is virtually eliminated and savings are "appreciable," officials say.

From 11 diet kitchens on patient floors, Scotsman Super Flakers provide ice around the clock. Ice is used constantly for ice packs, body swellings and the patient's general comfort. Beverages are chilled and fruits and salads are bedded in ice. An additional Scotsman Super Cuber provides big, round, ice cubes as required.

Scotsman ice machines have earned the approval of Wesley officials and many other hospitals executives as a dependable source of pure ice that costs as little as 8¢ a hundred pounds. If you use ice in quantity, you need Scotsman ice machines.

Clean, pure Scotsman ice is always available for use in ice bags and for other patient needs at Chicago Wesley Memorial Hospital.

Scotsman Super Cubes efficiently chill milk cartons in the hospital cafeteria. Cubes are big, round, solid for long cooling.

A bed of Scotsman Super Flakes keeps salads crisp, cold, attractive in the Chicago Wesley Memorial hospital cafeteria.

DOZENS OF SCOTSMAN MODELS FOR EVERY ICE NEED!

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Modernize with Modern Ice!

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YES! Please send complete details, including new "Ideas on Ice" booklet on Scotsman Ice Machines.

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97 Front Street, Albert Lea, Minnesota
EXPORT OFFICE: 15 William St., New York, N.Y.

ABOUT PEOPLE

(*Continued From Page* 84)

of Highland View and another county owned hospital, Cleveland Metropolitan General. Mr. Walls, who was Mr. Marquand's assistant, was promoted to director of Highland View. He went to the hospital in 1952 after receiving his master's degree in hospital administration from Northwestern University.

Hugh J. Maher has been appointed assistant director of Germantown Dispensary and Hospital, Philadelphia. He has been associated with Lankenau Hospital, Philadelphia, as an administrative resident and administrative assistant. He majored in hospital administration and received a master's degree in public health from Yale University.

Dr. Hardy A. Kemp, director of professional services at Veterans Administration Hospital, Portland, Ore., has been appointed manager of the V.A. hospital, Atlanta.

Joseph Shuckerow has been named assistant administrator of Staten Island Hospital, Staten Island, N.Y. Mr. Shuckerow is a graduate of the School of Public Health and Administrative Medicine, Columbia University, and took his residency at St. Luke's Hospital, New York.

Lester C. Palmer, administrator of Community Hospital, Council, Idaho, has been named administrator of Wallowa Memorial Hospital, Enterprise, Ore. Mr. Palmer succeeds **William J. Yeats,** whose new appointment was announced in May.

W. Howard Miles has been appointed assistant administrator of the Amarillo Hospital District, Amarillo, Tex. Mr. Miles was formerly administrative assistant of Shannon West Texas Memorial Hospital, San Angelo, Tex. He received his master's degree in hospital administration from Northwestern University.

Victor M. Sledge has been named administrator of Veterans Memorial Hospital, Bradenton, Fla., succeeding **J. C. Fletcher.** Mr. Sledge was administrator of Muhlenberg Community Hospital, Greenville, Ky.

Aladino A. Gavazzi has been appointed assistant manager of the Veterans Administration Hospital, Dwight, Ill. He was formerly a special assistant at Veterans Administration Research Hospital, Chicago.

(*Continued on Page* 154)

CLEAN AND DESTROY BACTERIA IN ONE STEP WITH NEW DI-CROBE GERMICIDAL CLEANER

For the first time, a soapless anionic detergent and a phenolic germicide have been successfully combined. Di-Crobe Germicidal Cleaner cleans, disinfects and deodorizes most hospital surfaces in one easy step.

Di-Crobe is bactericidal under use dilutions. Quick-cleaning action and germicidal power remain stable, even when exposed to heavy soil. Hard or cold water may be used without fear of creating a soap film or of destroying conductivity.

Di-Crobe kills a broad spectrum of microbes, including resistant Staph, at very high dilutions. When not rinsed, Di-Crobe leaves a lasting antibacterial blanket. It is also non-toxic and non-irritating. See our representative, the Man Behind the Huntington Drum, for full details and send for the Di-Crobe Germicidal Cleaner Research Bulletin to get annotated test results.

Where research leads to better products... **HUNTINGTON**

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Dr. John H. Travis has retired as director of Manhattan State Hospital, New York. Dr. Travis was appointed clinical director at Creedmoor State Hospital, then became first assistant physician, and later served the hospital in an administrative capacity as assistant director. He became acting medical inspector in the Albany central office in 1937 and superintendent at Willard State Hospital in 1938 where he remained until his appointment at Manhattan State Hospital.

Sanford K. Bronstein has been appointed administrator of Cedars of Lebanon Hospital now under construction in Miami. Mr. Bronstein has been associate executive director, Jackson Memorial Hospital, Miami.

Dr. Ralph S. Methany, manager of Veterans Administration Hospital, Boston, has been named area medical director for V.A. at St. Paul. Dr. Methany succeeds **Dr. Oreon K. Timm,** whose transfer to the VA's central office in Washington, D.C., was announced in the May issue of The MODERN HOSPITAL.

E. Geoffrey High has been appointed assistant director, Brooklyn Hospital, Brooklyn, N. Y. Mr. High is a graduate of the School of Public Health and Administrative Medicine, Columbia University, and has been serving as assistant to the dean of the School of Public Health at Columbia.

Ben Clark has been named administrator of Humphries Memorial Hospital, Fernandina Beach, Fla. Mr. Clark is currently administrative assistant at City-County Hospital, LaGrange, Ga.

Albert Richardson has been named superintendent of Allegheny Memorial Hospital, Sparta, N.C., succeeding **Charles Collins,** who resigned.

John R. Shannon has been appointed administrator, Chelsea Memorial Hospital, Chelsea, Mass. Mr. Shannon was graduated from the School of Public Health and Administrative Medicine, Columbia University, and was administrative assistant at Laconia Hospital, Laconia, N.H.

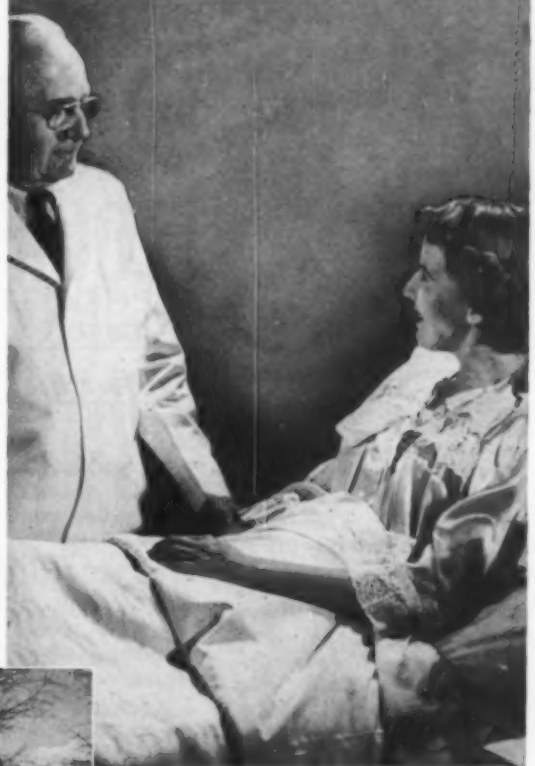
Ted E. Barner, community survey consultant, hospital services, Georgia Department of Public Health, has been appointed assistant administrator of DeKalb General Hospital, Decatur, Ga. Mr. Barner took the course in hospital administration at Georgia State College of Business Administration and served his residency at Kennetstone Hospital, Marietta, Ga.

(*Continued on Page* 156)

More PATIENT COMFORT when you

HEAT and COOL from ABOVE

(more quiet too!)



Where human comfort is a primary consideration . . . at hospitals, sanitariums, nursing homes, etc. . . . the Burgess-Manning Radiant Acoustical Ceiling provides maximum patient comfort . . . in fact, it might have been designed especially for hospital use.

Combining thermal comfort conditioning with acoustical control in the same unit, the Burgess-Manning Radiant Acoustical Ceiling performs both functions — *heats or cools from above* by radiant energy, independent of air movement. There are no drafts — room temperatures are practically uniform from floor to ceiling. Too, the ceiling provides the best possible acoustical control to absorb noise, with maximum quiet for patient and staff.

Of even greater importance for the psychiatric or childrens' hospital, the Burgess-Manning Radiant Acoustical Ceiling eliminates hot radiators, baseboard convectors, registers, etc. . . . which, within reach of mentally irresponsible patients or children, might prove harmful. Thermostats can be accessibly placed for only authorized personnel use.

The Burgess-Manning Radiant Acoustical Ceiling offers more architectural design freedom, more usable floor space, greater versatility and flexibility. Its operational efficiency and the inherent advantages of radiant heat assure fuel economies, as well. The Ceiling operates with standard hot water heating or water chilling equipment, using standard controls.

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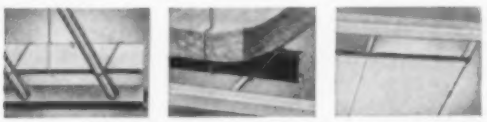
The Ceiling consists of a standard 1½" channel suspension system to which is attached a water circulating coil. This assembly supports an acoustical-thermal insulating blanket. The ceiling surface panels are in turn snapped directly on to the pipes with Burgess-Manning Spring Clips, providing direct conduction from the pipes to the panels. Adapters are available for the installation of Recessed Light Troffers.



Write for Bulletin No. 138-3 . . . the complete story of the Burgess-Manning Radiant Acoustical Ceiling for complete patient comfort.

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The BURGESS MANNING **3-WAY** FUNCTIONAL CEILING

North Carolina Baptist Hospital, Winston-Salem, N. C., where the Burgess-Manning Radiant Acoustical Ceiling provides complete patient comfort.

Department Heads

Sister Mary Anthony, R.N., has been appointed director of nursing at St. Anthony Hospital and School of Nursing, Columbus, Ohio. Since 1954, Sister Mary Anthony, S.F.P., has been director of nursing at St. Margaret's Hospital, Kansas City, Kan., and director at St. Elizabeth Hospital, Covington, Ky. She is a graduate of St. Mary's Hospital School of Nursing, Cincinnati.

Edward A. Messier has been appointed controller of Staten Island Hospital, Staten Island, N. Y. Mr. Messier is a graduate of the Bentley School of Accounting and is a member of the board of directors of the metropolitan chapter of the American Association of Hospital Accountants and the advisory committee on accounting of the United Hospital Fund. He was formerly controller of Beekman-Downtown Hospital in New York.

Teresa Niemek Mitchell, R.N., has been appointed assistant director, school of nursing, St. Margaret's Hospital, Kansas City, Kan. Mrs. Mitchell is a graduate of St. Margaret's School of Nursing, Kansas City, the College of St. Teresa, Kansas City, Mo., where she received her B.S.N., and of the Catholic University of America, where she received her master's degree in nursing.

Eva Erickson, formerly administrator of Children's Orthopedic Hospital, Seattle, has been appointed director of nursing at Bishop Clarkson Memorial Hospital, Omaha, succeeding **Amelia Miller,** who retired. Miss Erickson was previously director of nursing, director of the school of nursing, and administrator of Galesburg Cottage Hospital, Galesburg, Ill.

Dr. Frank J. Dixon, professor and chairman, department of pathology, University of Pittsburgh School of Medicine, will become the first director of the new department of experimental pathology, Scripps Clinic and Research Foundation, La Jolla, Calif. **Dr. Joseph D. Feldman,** current professor of pathology; **Dr. Jacinto J. Vazquez,** associate professor of pathology; **Dr. Gordon B. Pierce,** assistant professor of pathology; **Dr. William O. Weigle,** assistant professor of immunochemistry in pathology, and **Dr. Charles G. Cochrane,** Sarah Mellon Scaife Research Fellow in pathology on leave of absence from the Pasteur Institute, are also moving from Pittsburgh to the Scripps Clinic, which will be completed by July 1, 1961.

Dr. Albert L. Chasson has joined the laboratory staff of Mercy Hospital, Chicago, as associate pathologist and co-director of Mercy Hospital Laboratories. Dr. Chasson received his M.D. at the University of Cincinnati, interned at U.S. Marine Hospital, Baltimore, and completed three years in residency at DePaul Hospital, Norfolk, Va., and one at the University of Kansas Medical Center.

Mary Maar has been appointed director of nurses at Wabash County Hospital, Wabash, Ind. Mrs. Maar had been director of nurses at Logansport Memorial Hospital, Logansport, Ind. **Mrs. Keith Miller,** who had been serving as acting director of nurses during the last year, was named assistant director of nurses.

Thomas G. Fowler, a retired Navy lieutenant commander, has been appointed director of housekeeping services at Alexandria Hospital, Alexandria, Va. (*Cont. on Page* 158)

Maintenance and Purchasing had an $850 huddle—*about tissue!*

Maintenance knew tissue was an expense worth considering—and had some ideas on how to keep costs down. But, Purchasing knew economy starts with initial expenses and investigated tissue costs. Both had the same idea, the same solution: Fort Howard tissue. And Fort Howard tissue was an $850 a year savings solution to their cost problems.

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Miscellaneous

Thomas Tierney, executive director of the Colorado Blue Cross Plan, has been appointed a vice president of the Blue Cross Association. In announcing the appointment, James E. Stuart, association president, said that Mr. Tierney had taken a leave of absence from his former position and would be in charge of plan enrollment.

Richard Brooke Jr. has resigned his position as claims coordinator for Blue Cross-Blue Shield of Florida. Mr. Brooke was formerly administrator of Riverside Hospital, Jacksonville, Fla.

Dr. Sidney R. Garfield and **Dr. Clifford H. Keene** have been elected to the boards of directors of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, the Kaiser Foundation School of Nursing, the Kaiser Foundation Health Plan of Oregon, and the Utah Permanente Hospital, Dragerton, Utah. In addition, Dr. Keene was elected to the new management position of vice president and general manager of the various organizations. Dr. Garfield, vice president of the Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, is responsible for the planning of the Kaiser medical facilities in the West and Hawaii.

Dr. S. Garfield

Dr. C. H. Keene

Ronald H. Orr, administrator, Grays Harbor Community Hospital, Aberdeen, Wash., has been elected president of Washington Blue Cross (Washington Hospital Service Association). Mr. Orr, a past president of the Washington State Hospital Association, succeeds **John A. Dare,** who is administrator, Virginia Mason Hospital, Seattle.

Peter C. Goulding has been named director of the bureau of public information of the American Dental Association. Mr. Goulding has been secretary of the association's council on scientific sessions and, in 1958 was secretary of the centennial staff committee for the association's 100th anniversary, which was celebrated in 1959.

Dr. T. F. Sellers has retired as director of the Georgia Department of Public Health, after 42 years with the department. Dr. Sellers received his master's degree from the University of Michigan and his medical degree from Emory University School of Medicine. He was responsible for the creation of the Division of Hospital Services in the department.

Deaths

William A. Wyckoff, administrator of Samson Community Hospital, Glasgow, Ky., died early in April. During World War II, he was associated with the U.S. Army Surgeon General's staff in Europe. Mr. Wyckoff was a past president of the Kentucky Hospital Association and had been serving on its board of trustees. He had been a member of the American College of Hospital Administrators and the Nurses League of Kentucky.

Sister Basil, former administrator of St. Margaret's Hospital, Montgomery, Ala., died recently. Sister Basil had retired because of her illness.

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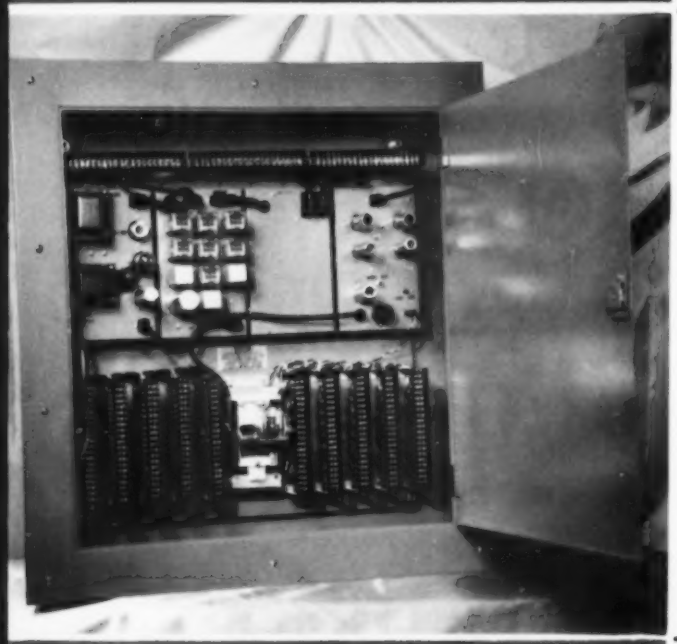
For The Hospital Of The Future

Room stations have satin finish stainless steel faceplate . . . rugged molded plastic housing . . . station safety break-away link . . . nylon cord assembly (can be sterilized) . . . these are some of the advanced features characteristic of the modern Nurses Call Systems offered by Couch . . . the most complete line available . . . in modular units so you can tailor a system to fit the requirements of your hospital building.

Room Station



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Control panel for automatic systems has plug-in components . . . is completely pre-wired for full capacity . . . UL approved . . . selectors tested for over 100 million operations with no sign of failure . . . features typical of a complete line of equipment . . . including room stations, nurses stations, bath stations . . . annunciators, corridor lights . . . from simple visual systems to automatic audio-visual systems . . . all available in modular unit construction.

Control Panel for
Automatic Nurses Call System

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Dependability In Self-Contained Units

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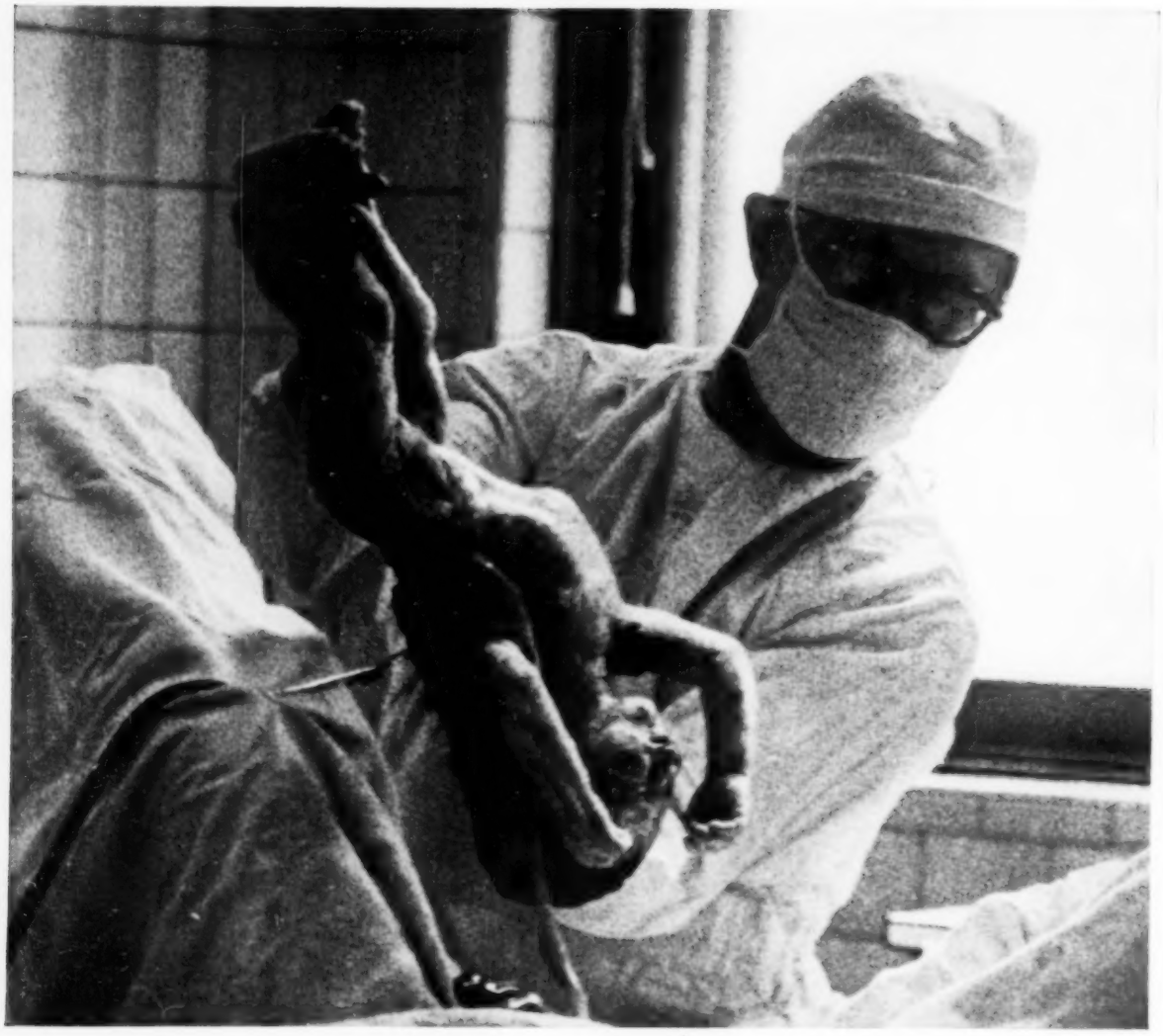
every 7½ seconds another life begins



. . . and 8% are premature

4,350,000* babies will be born in the United States this year—and 8% will be premature. These premature infants should be given every chance for survival. Does your nursery have enough ISOLETTE® incubators?

The ISOLETTE incubator alone provides precise, continuous, fully-automatic control of temperature, humidity and oxygen—vital factors of the premature infant's environment.

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To be ready for the increasing number of premature births—and for optimal protection of even the tiniest infant—make sure your nursery has enough ISOLETTE incubators.

*4,320,000 births were recorded by U.S. Dept. of Comm. in 1959.

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TERMS: 30¢ a word—minimum charge of $6.00 regardless of discounts. For "key" number replies add five words. Ten per cent discount for two or more insertions (after the first insertion) without changes of copy. Forms close 15th of month. The Modern Hospital, 919 N. Michigan Ave., Chicago 11, Ill.

POSITIONS WANTED

ADMINISTRATOR—Seeks challenge, present position 5 years; experienced all phases building, expansion, equipping, staffing, organization and personnel programming, cost studies, staff, board, employee, public relations, etc; response sought from progressive hospital only; minimum salary acceptable $18,500; all replies confidential. Write MW 76, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Ill.

ADMINISTRATOR—Nursing home; experienced; energetic, industrious, organizer, sympathetic; business education, former owner operator; age, under 50; unemcumbered.; consider salaried position or lease option. Apply Mrs. Wilkerson, 1705 South Cheyenne Avenue, Tulsa, Okla.

ANESTHETIST—Male; well qualified for all types of modern anesthesia and agents; twelve years experience, general surgery, bronchoscopy, chest spinal, caudal; excellent references. Apply MW 78, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Ill.

LIBRARIAN—Medical records; registered, extensive experience; B. A. Degree; minimum beginning salary $7,200, annually; available August 1, 1960. Apply MW 75, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

MICHIGAN C.P.A. wishes to enter hospital management or controller field; experience 3 years public accounting, 2 years office administration, 3 years varied office experience; familiarity with cost, I.B.M. applications, personnel, systems and procedures, financial control and management problems; age 31, single; will move for challenging opportunity. Apply MW 80, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

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ADMINISTRATOR—Five years, superintendent, 700-bed teaching hospital; any locality; FACHA.

ASSISTANT ADMINISTRATOR—29; BS, Pharmacology; MHA; 2 years, administrative & supply officer, USAF; completing administrative residency, 800-bed, medical school affiliated hospital.

PATHOLOGIST—46; several years, chief, pathology, 500-bed hospital; Diplomate, clinical, anatomy & neurological pathology; outstanding specialist seeking only challenging opportunity; any locality.

RADIOLOGIST—35; trained Mayo's; 4 years, private radiological practice; prefers chiefship in hospital; Diplomate, diagnostic, therapy & isotopes; any locality.

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ASSISTANT ADMINISTRATOR—B.S. Business Administration; M.H.A.; since completing residency, teaching hospital, has served as its personnel director.

PATHOLOGIST—Diplomate; FACP; 8 years director of Pathology, 350-bed general hospital, consultant to several others.

RADIOLOGIST—University hospital training in radiology, including radioisotopes; M.S. (Radiology); 4 years group association; Diplomate (Diagnosis & Therapeutic Radiology).

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Miss Elsie Dey, Director
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ADMINISTRATOR—Age: 31 years; B.B.A. Degree; M.S. Degree, Hospital Administration; 5 years assistant director, 300-bed hospital, midwest; desires to re-locate.

ASSISTANT DIRECTOR—B.S. Degree, Business Administration. 8 years experience; chief laboratory technician; Michigan.

COMPTROLLER—C.P.A.; 15 years experience, large firm; 5 years 350-bed hospital, Maryland; well recommended.

BUSINESS MANAGER—Degrees, Law and Accounting; 6 years experience; 100-250 bed hospital, east; will consider New England or south.

ADMINISTRATOR—R.N.; 25 years experience nurse executive and administrator; available.

EXECUTIVE HOUSEKEEPER—2 years assistant, 200-bed Illinois hospital; 2 years director, housekeeping services; 150-bed Ohio hospital.

PHARMACIST—Chief; M.S. Degree, Hospital Pharmacy; 2 years associated with large teaching hospital; 3 years present position.

POSITIONS OPEN

ADMINISTRATOR—Junior assistant hospital; $7396 to $8748 annually; college graduate; completion of postgraduate course in hospital administration; experience in hospital administration preferred; sound annuity and pension system including social security; liberal paid holiday, vacation, medical and life insurance and sick allowance. Formal application must be on file by 4 PM August 3, 1960, MILWAUKEE COUNTY CIVIL SERVICE COMMISSION, Room 206, Courthouse, Milwaukee 3, Wisconsin.

ADMINISTRATOR—Hospital; male, experienced for new modern 25-bed community hospital in progressive northwestern Pennsylvania town; laboratory and X-ray experience desired. Send application to V. L. Miller, 107 Katherine Street, Port Allegany, Pennsylvania.

ANESTHETISTS—Wanted male or female for 35-bed hospital; $600.00 with maintenance. Apply MO 312, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST—Nurse; beginning salary $500.00 or more depending on qualifications; ample free time; off call. Reply MO 313, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETISTS—Nurse; for 220-bed community hospital; working with private group; two full time M.D.'s, four nurses, all agents and techniques; modernization program going on; two and one-half hours from Boston and New York. Write G. J. Carroll, M.D., WILLIAM W. BACKUS HOSPITAL, Norwich, Conn.

ANESTHETIST—Nurse; for 604-bed general hospital, no pediatric department, 40 hour week, plus overtime, salary open, generous employee benefits. Apply Personnel Office, AKRON CITY HOSPITAL, 525 East Market Street, Akron 9, Ohio.

ANESTHETIST—Nurse; $500; new and modern surgery, unusually strong and well diversified surgical staff; good opportunity in new 260-bed expanding hospital; college town location; good personnel policies, 40 hour week, 7 holidays, hospitalization, social security. Apply F. J. O'Brien, Administrator, CHAMBERSBURG HOSPITAL, Chambersburg, Pennsylvania.

ANESTHETIST—Nurse; wanted for 57-bed hospital; two anesthetists employed; salary open; details on request. Contact Administrator, SID PETERSON MEMORIAL HOSPITAL, Kerrville, Texas.

ANESTHETIST—Nurse; to complete staff of three for modern 100-bed hospital; winter ski and summer boating area in beautiful southern Vermont; salary open—commensurate with qualifications; 4 weeks vacation, sick time, Blue Cross, etc. Apply Ronald H. Neal, M.D., Chief, Department of Anesthesiology, SPRINGFIELD HOSPITAL, Springfield, Vermont.

ANESTHETIST—Nurse; 61-bed hospital with addition in progress; located in the Shenandoah Valley; inexperienced salary $450 per month with raise in 6 months and yearly thereafter; experienced $475 per month and raises; shoes and uniforms furnished; excellent staff. Contact Administrator WAYNESBORO COMMUNITY HOSPITAL, Waynesboro, Virginia.

ANESTHETIST—Nurse; female, accredited modern 250-bed hospital; all new surgery wing; department directed by anesthesiologist starting wage $500 plus liberal annual increase, three weeks vacation, health insurance, sick leave, retirement plan; American Board surgeons. Apply to Elmer J. Berg, Business Manager, GUNDERSON CLINIC, 1836 South Avenue, La Crosse, Wisconsin.
(See additional Anesthetists on page 176)

DIETITIAN—Assistant; needed for 400-bed general hospital; excellent opportunity for ADA registered, hospital trained person; possibility of working in either therapeutic or administrative areas; salary consonant with training and experience; 40 hour week, social security and pension plan. Apply Personnel Office, ARKANSAS BAPTIST HOSPITAL, Little Rock, Ark.

DIETITIAN—ADA for therapeutic work; salary $4,030 plus vacation, sick leave, choice of two pension plans, drugs at discount, free meals while on duty and free laundry of uniforms; excellent working conditions. Write Personnel Manager, DUVAL MEDICAL CENTER, Jacksonville 6, Florida.

(Continued on page 162)

classified advertising

POSITIONS OPEN

DIETITIAN—Position being created by opening of 120-bed rehabilitation addition to Iowa Methodist Hospital; excellent opportunity for ADA registered hospital trained person; possibility of work in either therapeutic or administrative areas; good pay, liberal benefits. Apply Personnel Director, IOWA METHODIST HOSPITAL, Des Moines 14, Iowa.

DIETITIAN—Therapeutic; 253-bed J.C.H.A. approved general hospital, new kitchen and cafeteria. Send resume including experience and salary desired to Administrator, W. A. FOOTE MEMORIAL HOSPITAL, 205 N. East Avenue, Jackson, Michigan.

DIETITIAN—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply Director of Dietetics, BARNES HOSPITAL, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Wanted; Must be registered and well qualified to handle a 285-bed general hospital; excellent salary with full maintenance if desired; we have a beautiful nurses' home, all private rooms nicely furnished, located 36 miles from New York City, served by Lackawanna railroad as well as several bus lines. Write giving full qualifications to DOVER GENERAL HOSPITAL, Jardine Street, Dover, New Jersey, Attention: C. T. Barker, Director.

DIETITIAN—Therapeutic; new 516-bed approved cancer research hospital; $4668.00 to start for 40 hour week and liberal fringe benefits; Apply to Personnel Director, ROSWELL PARK MEMORIAL INSTITUTE, 666 Elm Street, Buffalo 3, New York.

DIETITIANS—Staff or therapeutic; ADA approved; needed at once; approved, private, non-profit, 604-bed general hospital; good employee benefits; laundry service and meals; salary open. Apply to Miss Jo Ann Brown, Personnel Director, AKRON CITY HOSPITAL, 525 E. Market Street, Akron, Ohio.

DIETITIAN—Chief; A.D.A.; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open, 4 week vacation; also: Assistant dietitian; salary open, 2 week vacation, 2 meals and laundry furnished; 40 hour week, 6 holidays; social security; Blue Cross and Blue Shield available. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIAN—A.D.A. preferred but not essential; 71-bed general hospital; liberal personnel policies; located in winter and summer resort area. Write: stating references and salary desired to Personnel Director, KERBS MEMORIAL HOSPITAL, St. Albans, Vermont.

(Continued on page 164)

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DIETITIAN—Administrative; for 200-bed hospital, eastern Ohio; salary open with maintenance, vacation, sick benefits, and other benefits such as Blue Cross, Blue Shield and social security are available. Apply to Nell Robinson, Superintendent, THE EAST LIVERPOOL CITY HOSPITAL, East Liverpool, Ohio.

DIETITIAN—Vacancies in a chain of ten general hospitals with active APC's operated in coal mining region of eastern Kentucky, southwestern Virginia and southern West Virginia; ADA membership required with experience in administration, teaching and/or therapeutics; food clinic experience desirable; salary at the rate of $4,860 or $5,880 per annum, depending upon experience and training; 40 hour week, 4 weeks paid vacation, 7 paid holidays, laundry of uniforms; social security, employees health plan. Call or write: THE MINERS MEMORIAL HOSPITAL ASSOCIATION, Box #61, 110 Logan Street, Williamson, West Virginia. Phone: BELmont 5-2424.

DIETITIAN—Prefer A.D.A. but not required; full time between two recently expanded 60-bed general hospitals located 12 miles apart, new dietary facilities included; easy driving distance to Madison, Milwaukee, Rockford and Chicago; salary consistent with training and experience; six holidays; liberal personnel policies; Blue Cross and physicians service available. Send resume, including references, experience, date available and salary desired to Mr. Charles E. Welch, Administrator, MEMORIAL COMMUNITY HOSPITAL, Edgerton, Wisconsin.

DIRECTOR NURSING SERVICE—300-bed general hospital; strong supervisory experience necessary; excellent opportunity for the person who qualifies in personality, training and experience; salary open; located northeastern Illinois. Submit complete resume and salary desired to MO 307, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

ASSOCIATE DIRECTOR OF NURSING EDUCATION—For accredited school of nursing with 100 students; 302-beds, 40 bassinets, general hospital in suburban Philadelphia; Masters degree with teaching experience required; salary depends on preparation and experience good personnel policies. Apply MO 311, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING—Modern, nonprofit 286-bed general hospital; fully accredited, approved internship, residency programs; to expand to 470-beds; located in beautiful suburban setting close to Detroit; require master's degree with major in nursing service and administrative experience; salary dependent upon experience and qualifications. Write Director's office, OAKWOOD HOSPITAL, Dearborn, Michigan.

DIRECTOR OF NURSING SERVICE—242-bed, general, accredited hospital; experience desirable; excellent starting salary; progressive policies. Write James G. Carr, Jr., Administrator, MEMORIAL HOSPITAL OF NATRONA COUNTY, Casper, Wyoming.

(Continued on page 166)

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Bathroom fixtures and floors should be scrubbed or wiped daily with a Staph-trole solution.

Staph-trole effectively "destroys" odors because it destroys the bacteria which produce them.

Surfaces cleaned with Staph-trole resist re-contamination and stay sanitary and odor-free for a far longer time than possible with ordinary cleaners.

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. . . and there are a lot more . . . for this versatile new germicidal cleaner is a handy item for the administrator who wants to maintain highest antiseptic and *staph-free* standards.

Lightning-Fast Staph-Killer. Even at dilutions of 1:200, Multi-Clean STAPH-TROLE destroys *staphylococcus aureus* quickly and effectively. (Phenol coefficient is 18.7).

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Powerful Cleaner. STAPH-TROLE combines a potent new germicide with a fast-penetrating non-ionic detergent to provide an ideal cleaner for any surface where *staphylococcus* or other bacteria may lurk. It's especially recommended for floors, walls, beds, furniture, bathroom facilities, surgery, kitchen, cafeteria, garbage rooms, etc. An excellent and long-lasting de-odorizer, too . . . because of its ability to destroy odor-forming bacteria.

Free Handbook, Film on Hospital Cleaning. Ask your Multi-Clean Distributor for free 8-page bulletin on Hospital Housekeeping or a showing of new 20-minute sound filmstrip. Ideal for training housekeeping staff. Or write direct to Dept. MH-85-70, Multi-Clean Products, Inc., St. Paul 16, Minn.

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POSITIONS OPEN

DIRECTOR SCHOOL OF NURSING—To establish and direct three year diploma hospital school of nursing replacing four year degree program under affiliated university terminating its program with graduation of students entered in 1958; in a beautiful new 276-bed hospital; Masters Degree preferred; salary open based on preparation and experience; liberal personnel policies; social security; group hospitalization; sick leave; paid vacation. Apply to Vernon T. Spry, Administrator, METHODIST HOSPITAL, 6500 Excelsior Boulevard, Minneapolis 26, Minnesota.

DIRECTOR—Personnel; to organize and establish a centralized personnel department in a hospital which will have 253-beds and 44 bassinets upon completion this summer of a large expansion and remodeling program; candidate must have had good experience in this field; degree desirable; salary open; Send detailed resume of training, experience and salary desired to Robert G. West, Administrator, W. A. FOOTE MEMORIAL HOSPITAL, 205 N. East Avenue, Jackson, Michigan.

HOUSEKEEPER—Executive; large university affiliated hospital in New York State; prefer formal educational background in field; must be able to participate in top management. Apply MO 305, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

INSTRUCTORS—Medical, surgical and maternity; degree required; salary differential for M.A. degree; excellent hospital benefits, 40 hour week. Contact Personnel Office AKRON CITY HOSPITAL, 525 E. Market Street, Akron 9, Ohio.

INSTRUCTOR—Medical & surgical; Degree in Nursing or Nursing Education, 150-bed hospital, modern; Central Pennsylvania; $4800 to start; send background information. CLEARFIELD HOSPITAL, Turnpike Avenue, Clearfield, Pennsylvania.

LIBRARIAN—Assistant medical records; registered, for 279-bed fully accredited general hospital in outstanding suburban community; excellent personnel policies and benefits; teaching program for interns and residents; in 4th year with P.A.S.; modern office equipment, full record department staff, cooperative medical staff; salary commensurate with experience. Contact: Director of Personnel, THE GREENWICH HOSPITAL ASSOCIATION, Greenwich, Connecticut.

LIBRARIAN—Medical record; 300-bed general hospital; excellent opportunity for recent graduate, or experienced individual; convenient location, 35 miles southwest of Chicago. Write G. W. Hoeffel, SAINT JOSEPH HOSPITAL, 372 North Broadway, Joliet, Illinois.

LIBRARIAN—Medical record; registered or eligible for registration; 260-bed general hospital; pleasant working conditions; fine medical staff relationships; progressive administration; salary open; submit complete resume to R. W. Hunsaker, Assistant Administrator, BROCKTON HOSPITAL, 680 Centre Street, Brockton, Massachusetts.

(Continued on page 168)

WHY THE PAGEMASTER® WAY IS THE QUIET, SURE WAY TO GET INSTANT CONTACT ■ ■ ■

Consider these facts about Pagemaster® selective wireless paging system by Stromberg-Carlson—and you'll see why this system is ideally suited to hospital use:

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LIBRARIAN—Medical record; registered; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open and commensurate with ability and experience. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

LIBRARIANS—Registered medical record; Positions in two of ten general hospitals located in eastern Kentucky, southwestern Virginia, and southern West Virginia, operating in a regional pattern; one position can be filled by a recent graduate, other position requires 5 years experience for consultative duty to community hospitals in region; salary $4440 and $4860 per annum; 40 hour week, 7 paid holidays, 4 weeks vacation, social security, employee health and increment program. Write: MINERS MEMORIAL HOSPITAL ASSOCIATION, Box 61, Williamson, West Virginia.

NURSES—Surgery registered; supervisor and one scrub nurse, eligible for registration in California; 50-bed hospital; salary $400 per month plus fringe. Apply Administrator, RIDGECREST HOSPITAL, Ridgecrest, California. Phone 8-2351

NURSES—Psychiatric; rewarding careers for both men and women as professional nurses in nation's largest Federal mental hospital; progressive teaching program and opportunities for participation in National Institutes of Health research projects; beautiful hospital grounds in residential section near U.S. Capitol; several near-by universities offer opportunities for advanced education; positions are for staff, head and supervisory nurses in career civil service with the Department of Health, Education and Welfare; annual salaries range from $4040 to $8230, depending upon education, experience and prior Federal service; liberal fringe benefits include group health and life insurance, retirement benefits, and generous vacation and sick leave. Write Director of Nurses, Office H, SAINT ELIZABETHS HOSPITAL, Washington 20, D. C.

STAFF POSITIONS—All clinical areas including psychiatry, respiratory-rehabilitation center; beginning salary $300 monthly; periodic increases; 3 weeks annual vacation; opportunity for college study, bachelor's degree program. Write Head, Department of Nursing Service, EUGENE TALMADGE MEMORIAL HOSPITAL, MEDICAL COLLEGE OF GEORGIA, Augusta, Georgia.

NURSES—Registered; operating room, delivery room and general duty for 325-bed hospital in western suburb 16 miles west of Chicago's loop; starting salary for experienced operating room nurses $400.00; starting salary for delivery room nurses $365.00; starting salary for general duty $350.00; differential of $15 for PM and night shifts; 6 paid holidays and other liberal benefits. Apply Mrs. Emily Strong, Personnel, MEMORIAL HOSPITAL, Elmhurst, Illinois.

NURSE—Registered; for psychiatrically oriented private residential treatment center for emotionally disturbed children with controlled epilepsy; experience not necessary; starting salary $325 plus usual fringe benefits. Send photo, complete resume and date of availability to Head Nurse, NATIONAL CHILDREN'S CENTER, Leesburg, Virginia. (35 miles west of Washington, D. C.)

NURSES—Registered; labor room; general staff duty; all shifts; 3-11 and 11-7 supervisor. Apply Director of Nurses, MARTINSVILLE GENERAL HOSPITAL, Martinsville, Virginia.

PHARMACIST—Registered; male or female; for 400-bed general hospital in Hawaii, liberal personnel policies, hospitalization coverage, group life insurance, retirement, 40 hour week; starting salary $497.00. Write Personnel Director, THE QUEEN'S HOSPITAL, P.O. Box 861, Honolulu, Hawaii.

FIELD SALES COORDINATOR—Exceptional opportunity; A dynamically expanding, nationally recognized company has immediate requirement for man with hospital sales background to become a field sales coordinator for an aggressive organization which has developed and is continuing to develop advanced hospital patient service systems; if the challenge of promoting and supplementing the selling efforts of our field representatives in your own territory attracts you . . . if you have the initiative and follow-through ability with hospitals, administrators, architects, and engineers from specification to closing levels; excellent salary, supplementary compensations and benefits. Please reply to: SUNBEAM LIGHTING COMPANY, 777 East 14th Place, Los Angeles 21, California.

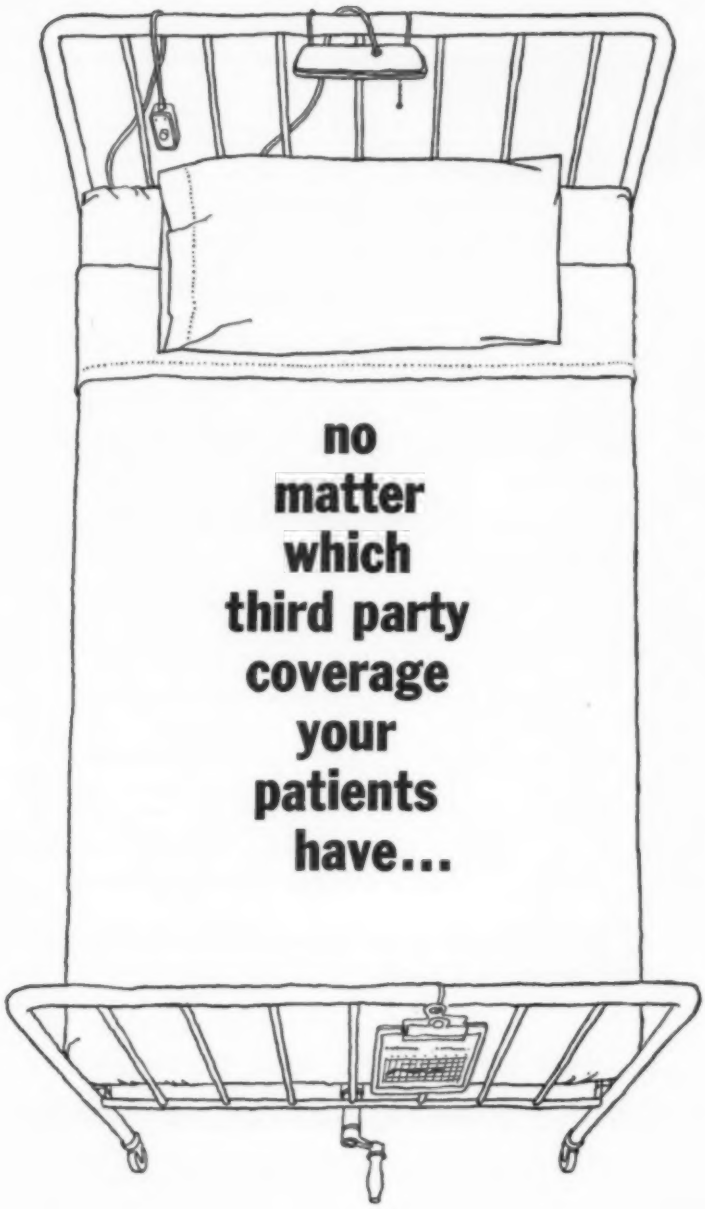
SALESMEN—Drugs; Call on hospitals with complete well accepted line of generically labelled pharmaceuticals; full or part time basis; may have companion line. Reply VITARINE CO., INC. 625 W. 55 St., New York 19, New York. Department 636.

SALES REPRESENTATIVES—For 3 multi-state territories (1) Louisiana-Mississippi & Alabama (2) Wisconsin & Illinois (3) Michigan & Indiana to sell hospital and institutional furniture thru dealers; experienced in contract or hospital selling field preferred; excellent permanent opportunity with top manufacturer for high earnings; include full resume. Reply to MO 314, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

SUPERVISOR—Operating room; JCAH accredited 350-bed general hospital, with NLN accredited school of nursing; operating room suite is new, modern and completely air conditioned; advance preparation and experience required; excellent personnel policies including group life insurance, Blue Cross, social security, vacation and sick leave benefits; salary open. Write stating age, experience, salary desired to Personnel Director, BETHESDA HOSPITAL, Oak St. & Reading Road, Cincinnati 6, Ohio.

SUPERVISOR—Obstetrical; responsible for the administration of a 53-bed obstetrical unit consisting of a delivery room and two floors; present hospital has 575-beds; starting a $2,500,000 building in the Fall which will house an entirely new obstetrical unit; department has full time obstetrical instructor; large school with no recruitment problem; salary $4740 with six month increases to $5340; retirement plan in addition to social security; hospital pays 5% of salary into fund and employee 3%; after 5 years of service, hospital provides a life insurance policy for the employee equivalent to a year's salary; hospital pays the policy; other liberal personnel policies and attractive living and teaching facilities; each room in the residence has its own bath and shower; hospital located in a beautiful 40 acre park; community has many cultural opportunities; one college in city; four universities have extension center or extension courses in the city qualifications: Baccalaureate Degree and past supervisory experience. Apply Director of Nurses, The READING HOSPITAL, Reading, Pennsylvania.

(Continued on page 170)



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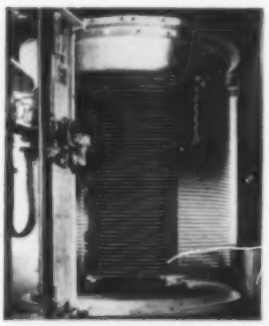

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SUPERVISORS—Excellent opportunities for qualified nurses, in new 200-bed wing to open with extensive clinic facilities modern equipped; fully approved by Joint Commission; intern-resident program, fully accredited school of nursing; liberal benefit program, 4 weeks vacation. Apply Personnel Director, CHRIST HOSPITAL, Cincinnati 19, Ohio.

THERAPIST — Occupational; for 253-bed J.C.A.H. approved hospital; will serve medical-surgical patients, as well as those patients on our new 30-bed mental health unit; must have a degree; salary commensurate with qualifications. Contact Administrator, W. A. FOOTE MEMORIAL HOSPITAL, 205 N. East Avenue, Jackson, Michigan.

THERAPIST—Physical; qualified; 71-bed general hospital with excellent growth potential; salary commensurate with ability; five day week; four week paid vacation; twelve days sick leave annually and seven paid holidays. Write: stating references and salary desired to Personnel Director, KERBS MEMORIAL HOSPITAL, St. Albans, Vermont.

TECHNICIAN—Qualified in both laboratory and X-ray for new 50-bed general hospital; 3 technicians employed; salary open. Apply MO 304, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNICIAN—Laboratory; new, air-conditioned building; A.S.C.P. membership desirable but not essential; in applying give qualifications and references; liberal vacation, sick leave and fringe benefits; salary open. Apply to Mr. Donald E. Gilbert, Administrator, BROCKTON HOSPITAL, 680 Centre Street, Brockton, Massachusetts.

TECHNOLOGIST—Medical; for 7 doctor clinic located in college town of 14,000; modern building and laboratory, salary open dependent upon experience and qualifications. Apply Business Manager, DAVIS CLINIC, Mt. Pleasant, Michigan.

The Medical Bureau

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ADMINISTRATORS — (a) Administrator; 200-bed hospital, all modern equipment; college town near summer, winter resorts, Wisconsin; top salary. (b) Administrator; eastern medical center; building program includes 400 beds; $15—18,000. (c) Administrator; dual hospital project 135-beds; rapidly growing southwest city; start $10,000 up. (d) Assistant administrator; building program under way to 500-beds; winter resort city on Mexican Border; progressive administration; good financial opportunity. (e) Assistant administrator; 165-bed hospital; recent graduate preferred; Great Lakes; $6000. (f) Nurse; male or female, manage new convalescent home near Vermont ski resorts; attractive salary. MH 7-1

(Continued on page 172)

ADMINISTRATIVE PERSONNEL — (a) Administrative assistant; large midwest hospital; excellent opportunity for advancement; $7300-$8800. (b) Business manager; brand new 75-bed hospital; historical southern city. (c) Personnel-public relations director; 300-bed progressive hospital; college town; top salary. (d) Food director; large southern hospital to $10,000. (e) Engineer; eastern hospital, $7500 up. MH 7-2

ANESTHETISTS—(a) Anesthetist; join staff brand new 150-bed hospital; deep south, to $9000. (b) Responsible for service small clinic, college resort town near Mexican Border; $9000. (c) Join staff new modern surgery; close to Carmel-By-The-Sea; San Francisco; $7000-$8500. (d) Only one on staff, 100-bed Florida hospital, near beaches; good opportunity. MH 7-3

DIETITIANS—(a) Chief; 300-bed hospital near New York City; $5500 up. (b) Charge of dietary facility, expanding hospital, suburban Chicago; $6000 up. (c) Therapeutic; 250-bed hospital; fashionable Florida ocean resort; $5000 up, plus. MH 7-4

DIRECTORS OF NURSING—(a) Director; service and school, 90 students; 300-bed hospital; commute New York City; to $10,000 start. (b) Director of Nursing; 165 students; 400-bed hospital; eastern seaboard medical center; top salary. (c) Director of Nursing; 400-bed university affiliated hospital, 200 students N.L.N. school; attractive salary plus furnished apartment; south. (d) Director of Nurses; renowned rehabilitation center, 200-bed hospital; midwest; $8000 up. MH 7-5

EXECUTIVE HOUSEKEEPERS—(a) Executive housekeeper; also charge of laundry, medium hospital, Colorado; excellent financial opportunity. (b) Manage housekeeping activities; 300-bed hospital; leading city, $5-$6000. MH 7-6

FOREIGN OPPORTUNITY—Nurses; staff, supervisor, O.B., O.R. experience, $7200-$10,000; leading oil company overseas operations. MH 7-7

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

MEDICAL RECORD LIBRARIANS—(a) Director; 350-bed university research center; high professional opportunity; south; (b) Chief; 130-bed hospital; most ideal year round climate; progressive city; busy seaport, Alaska; $5-6000 start. (c) Director, brand new 300-bed hospital, eventual expansion 500; department of 15; ability organize school; $6-7200; near Chicago. MH 7-8

ADMINISTRATORS—(a) Direct medical education; fully-accredited, 350-bed, general, voluntary hospital; 40 residents & interns; $15-18,000 plus excellent benefits; south. (b) New corporation; 150 bed hospital; requires seasoned administrator, skilled in economics of successful hospital operations; good salary plus possible profit sharing; warm climate. (c) JCAH 200-bed general; well-equipped; salary open; co-educational college town 30,000; midwest. (d) 75-bed, general county-operated hospital; $7200-$9000; small residential town near university medical center; mid-south. (e) New 50-bed, general hospital; plans to expand rapidly to 250-beds; will be staffed by Board men; requires MHA with residency completed; northeast. (f) Assistant; fairly large, general, voluntary, JCAH hospital; Hawaii. (g) Assistant administrator able direct fund drive; fairly large JCAH voluntary, general hospital; will become administrator of new hospital when built; about $12,000.

ADMINISTRATIVE POSTS—(h) Administrative assistants; university medical center, 350-bed hospital; requires degree in business or related field; report to business manager; over $6,000; California. (i) Business manager; 100-beds; Finger Lake region; east. (j) Comptroller; qualify develop into assistant hospital administrator; report to MACHA; fairly large, fully accredited general hospital; to $10,000; northeast. (k) Personnel director; qualify organize department to be created; 600-bed, medical school affiliated hospital; salary open; large city; university medical center; central. (l) Personnel, director; voluntary, general, JCAH, 175-bed hospital; good salary plus annuity; on Hudson River; NY.

DIRECTOR OF NURSES—(m) M.S., several years experience to have full charge nursing service, education, 400-bed university affiliated general hospital; $7200, full maintenance; south central.

EDUCATIONAL DIRECTOR—(n) Supervise 80 students in collegiate affiliated 3 year program; 200-bed general hospital; northwest.

NURSE ANESTHETISTS—(o) Approved general hospital 75-beds; lovely New England resort community 10,000. (p) General hospital 150-beds; to $7200; lovely small Southeastern community.

(Continued on page 174)

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POSITIONS OPEN

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332 Bulkley Building
Cleveland 15, Ohio

ANESTHETIST—(a) Midwest; $650 monthly.

ADMINISTRATOR—(a) R.N.; 60-bed hospital, Ohio. (b) R.N.; 85-bed hospital, east. (c) 50-bed modern convalescent hospital; New England.

ASSISTANT ADMINISTRATOR — (a) M.H.A. Degree; 5 years experience, in large hospital; salary $12,000. (b) 275-bed New Jersey hospital. (c) 100-bed Illinois hospital.

ADMINISTRATOR—(a) 250-bed hospital, under construction; large industrial city. (b) 80-bed hospital, Ohio.

OFFICE MANAGER—(a) Accountant; 275-bed western hospital. (b) 250-bed hospital, south central state.

DIRECTOR NURSING EDUCATION—$6,000.

DIRECTORS OF NURSING—(a) To $9,000. (b) Directors, nursing service; $6500.

MAINTENANCE DIRECTORS—(a) To $9,000. (b) Executive housekeepers; $5,000.

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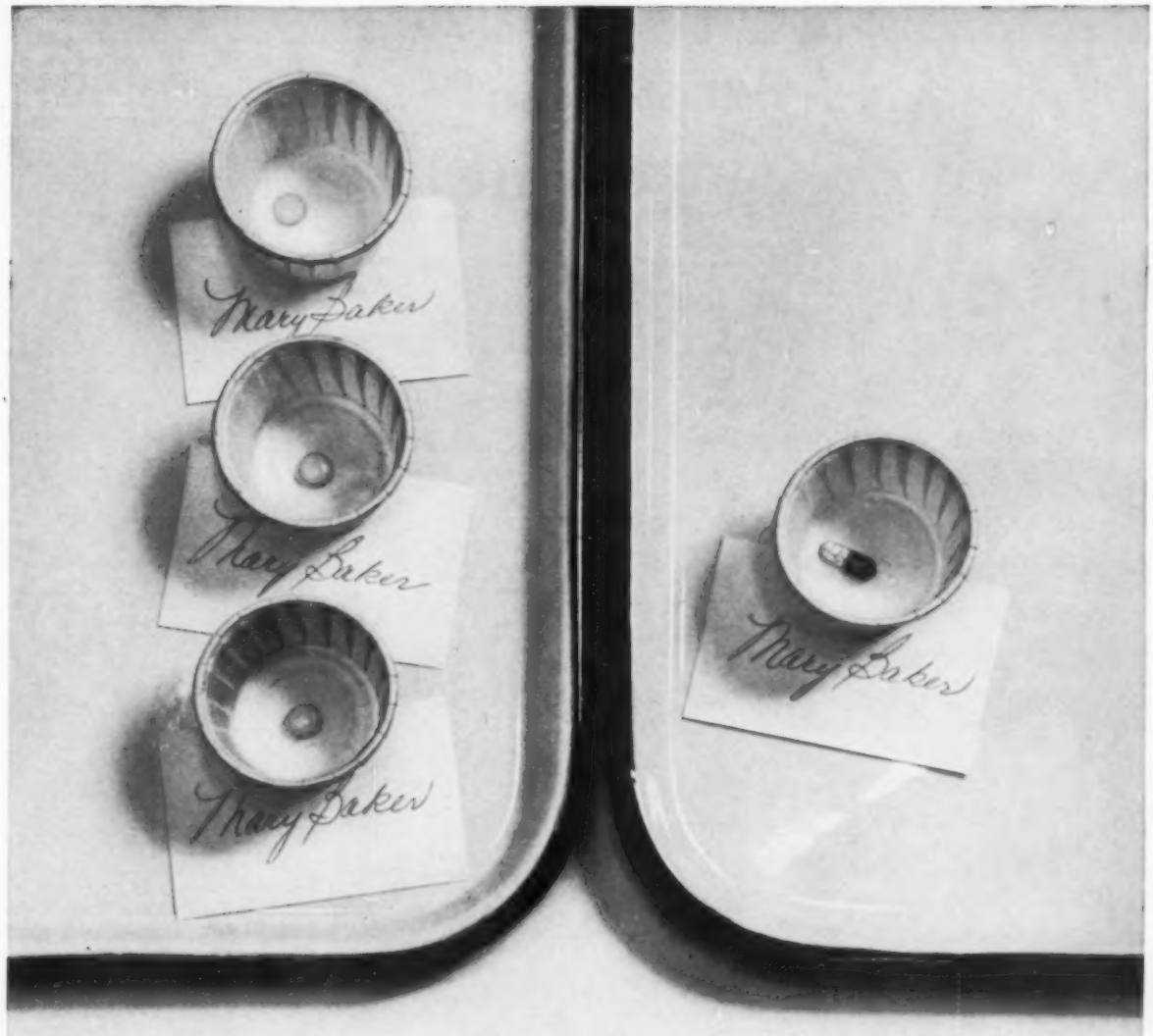
(Continued on page 176)



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FACULTY positions include Education Directors, Associate Director of Nursing Education, Assistant Director School of Nursing, Clinical Instructors — Medical, Surgical, Nursing Arts, OB, Fundamentals of Nursing, Pediatric Nursing, etc.

LABORATORY TECHNICIANS & TECHNOLOGISTS — X-RAY TECHNICIANS — Vacancies for male and female technicians. Salaries in most instances are open and depend on qualifications and experience of the individual. Others are quoted as salary, plus perquisites, plus living accommodations.

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The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

UNIVERSITY OF MICHIGAN offers an 18 month course for nurses interested in anesthesia. Accredited by the American Association of Nurses Anesthetists. Unlimited opportunities for endotracheal intubations open chest, and neuro surgery anesthesia. Stipend provided. For information write "School for Nurse Anesthetists, UNIVERSITY MEDICAL CENTER, Ann Arbor, Michigan".

MT. CARMEL MERCY HOSPITAL offers an 18 month course in Anesthesiology to registered nurses of accredited schools of nursing. Approved by American Association of Nurse Anesthetists. Stipend provided. Write for complete details regarding theoretical and clinical teaching and requirements for entrance. School of Anesthesia, MT. CARMEL MERCY HOSPITAL, Detroit 35, Michigan.

ST. MARY'S HOSPITAL, Minneapolis, Minnesota, offers a fifteen month course in anesthesiology to graduates (men or women) of accredited schools of nursing. The course includes theory and experience in all phases of modern anesthesia. Enrollment dates February, May, August and November. Direct Correspondence to Director, Department of Anesthesia.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition $100.00 approved by the American Medical Association. For further information, write the Director of Laboratories, BARNES HOSPITAL, 600 S. Kingshighway, St. Louis 10, Missouri.

BARNES HOSPITAL: Offers an 18 month post-graduate course in Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met, Miss Helen Vos, R.N., B.S., Educational Director, Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, BARNES HOSPITAL, St. Louis 10, Missouri.

LUTHERAN MEDICAL CENTER, 4520 Fourth Avenue, Brooklyn 20, New York. "School for Medical Record Librarians" Classes being formed now for September 1961.

ANESTHESIA SCHOOL FOR NURSES, St. Joseph's Hospital, Lancaster, Pennsylvania, 18 month course AANA approved. No tuition. Stipend. Large clinical experience for students including great many endotracheal intubations. For complete details write Dr. N. Kornfield, ST. JOSEPH'S HOSPITAL, Lancaster, Pennsylvania.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, PROVIDENCE LYING-IN HOSPITAL, Providence 8, Rhode Island.

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POSITIONS OPEN

ANESTHETIST—Registered nurse; for staff of two, 60-bed general hospital; two operating rooms in new wing; full maintenance provided in adjoining residence; pleasant working conditions. Apply stating salary expected to Miss Margaret Vopns, R.N., Administratrix, GRAFTON DEACONESS HOSPITAL, Grafton, North Dakota.

ANESTHETIST—Nurse; male or female; need be qualified to administer all types anesthesia; base salary $650 per month on call basis; liberal benefits; 86-bed hospital with 50-bed new addition; 11 Doctors comprise medical staff with average 3 majors per day; applicants must be available by September 1, 1960. Apply James A. Hall, Administrator VICTORY MEMORIAL HOSPITAL, 5th Avenue, Stanley, Wisconsin.

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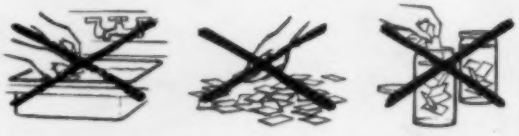
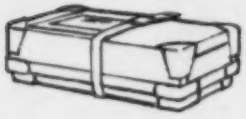
THIS IS HOW IT WORKS

Unused inner envelopes are collected. Hospital suture resterilization procedures are eliminated.



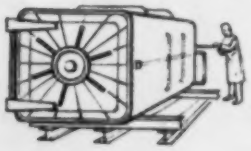
Sutures are returned to Surgical Products Division

in special mailing carton provided free.



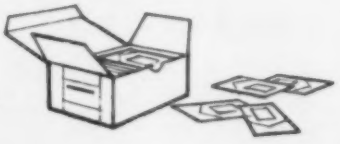
Sutures from each hospital are separately reprocessed.

Sutures are resterilized



and repackaged by *individual* lot.

Hospital's original sutures are returned, certified sterile U. S. P.



For complete details write to Sales Office below, Attention: SP Service Program Dept.

Producers of Davis & Geck Sutures and VIM® Hypodermic Syringes and Needles

CYANAMID
AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
30 ROCKEFELLER PLAZA
NEW YORK, N. Y.
SALES OFFICE: DANBURY, CONN.

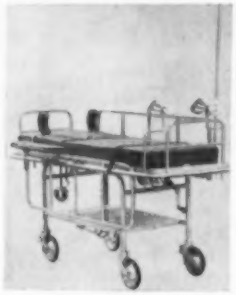
Edited by BESSIE COVERT

WHAT'S NEW

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 199. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

S-2702 Wheeled Stretcher For Recovery and Emergency Use

Conveniences for recovery and emergency use are offered with the new mem-



ber of the Shampaine line of wheeled equipment, the S-2702 Recovery Stretcher. The patient may spend his entire recovery period on the standard model, which includes safety siderails and an IV rod. A Trendelenburg lift of 15 degrees is available as an optional accessory, and the unit may be used as a labor room bed with the addition of equipment necessary prior to delivery. **Shampaine Co., 1920 S. Jefferson Ave., St. Louis 4, Mo.**

For more details circle #444 on mailing card.

Sanacoustic HCS System Heats, Cools and Sound-Conditions

All areas of a room, even those adjacent to window walls, can be used in comfort in the coldest or the hottest weather with operation of the Sanacoustic HCS System for radiant heating, cooling and sound-conditioning. The radiant ceiling not only provides draft-free heating and cooling, but maximum acoustical efficiency, absorbing up to 90 per cent of the sound that

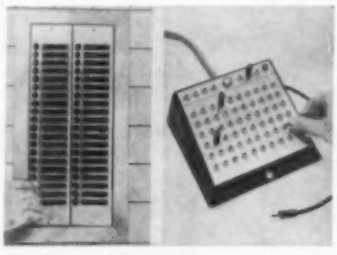
strikes it. Made entirely of standard components which are easy to install and economical to maintain, the HCS also leaves the total floor area free and unencumbered for flexibility in handling interior requirements.

Basic components of the HCS system include water-carrying coils for heating or cooling, a sound-absorbing insulating blanket, and perforated metal panels which form the finished ceiling and can be washed. To heat, circulating warm water inside the HCS tubing radiates to the steel panels, then downward to warm surfaces and occupants in draft-free comfort. In cooling, excess heat is radiated to the ceiling surface and carried away by cool water circulating in the same coils, with water temperature controlled to prevent condensation. The system is economical to install and effects fuel savings while providing comfort in any weather, hot or cold. **Johns-Manville Corp., 22 E. 40th St., New York 16.**

For more details circle #445 on mailing card.

Pagesaver System Eliminates Unnecessary Paging

Unnecessary page calls directed at doctors who aren't on the premises are eliminated with the Pagesaver System, which combines a Pagesaver Control Board with miniaturized in-and-out doctors' entrance registers. The operator interrogates her



control board before paging to determine whether or not a specific staff member has registered in. If he has not come in, she leaves a message alert for both herself and the doctor by inserting a cordless alert plug into the board. When he registers in, both the doctor's name on the register and the alert plug on the control board begin to flash and he checks with the operator, who can wait for him to contact her or initiate a standard page call. **Auth Electric Co., 34-20 45th St., Long Island City 1, N.Y.**

For more details circle #446 on mailing card.

Simplified Installation for Yale & Towne Mono-Locks

Rugged construction, attractive appearance with a broad range of designs, and simplified installation are features of the recently introduced Mono-locks. Developed at the Yale & Towne Research Center, they are designed to withstand continuous hard usage in hospitals and other public buildings. The Mono-locks are fully factory assembled, ready for the simple installation process. Knob designs match those of Yale cylindrical locksets, mortise locksets and panic exit device trim, and the Mono-locks can be keyed alike, master-keyed or incorporated into existing masterkey systems. **Yale & Towne Mfg.**

Co., 11 S. Broadway, White Plains, N.Y.

For more details circle #447 on mailing card.

Tomato Soup With Rice Now in Institutional Size

Added to the line of Heinz foods for institutional service is Condensed Tomato With Rice Soup in a 51-ounce can. The soup is also available in ready-to-serve form in the 7¾-ounce cans for vending and lunch counter service. The new soup is a combination of tomato soup with long-grain Patna Rice blended with seasoning and garnished with chopped parsley. **H. J. Heinz Co., P.O. Box 57, Pittsburgh 30, Pa.**

For more details circle #448 on mailing card.

"Courier" Copying Machine Weighs Only 25 Pounds

The "Courier," a compact, lightweight copying machine, operates on the "Thermo-Fax" dry, all-electric copying principle. Styled for desk-top use, the

unit weighs only 25 pounds and can be easily carried for use in any location. It is merely plugged in and turned on, eliminating the need for operator training, and makes copies in eight seconds or less without the use of chemicals or liquids. **Minnesota Mining & Mfg. Co., 900 Bush St., St. Paul 6, Minn.**

For more details circle #449 on mailing card.

(Continued on page 180)

Curved Metal Sides Give Fixture "Sculptured-Look"

The scientifically controlled low brightness feature of the Holophane Prismalume Controlens is combined with the Sunbeam

Sculpturama QRH7502 Series design to produce the "sculptured-look" of the new Visionaire lighting fixture. Illuminated, curved metal sides complete the shallow fixture and the sturdily framed panel has high transmission efficiency. It may be opened from either side on full-length "hook-on" hinges. **Sunbeam Lighting Co., 777 W. 14th Place, Los Angeles 21, Calif.**

For more details circle #450 on mailing card.

Improved Windjammer Tumbler Reduces Cycling Time

The 72-inch, 25-ring Windjammer Tumbler, a pre-dryer and conditioner for large capacity laundry installations, features advancements which result in more complete drying with a faster cycling time. The improved machine's gas steam line is increased two-thirds to a 1¼-inch size; the doors are completely perforated; a back chamber is added to prevent the clogging of lint; new cleanouts are in the vent, and improvements in the air cylinder system give a more positive action to sealing the doors against inside pressure. **Purkett Mfg. Co., Inc., Joplin, Mo.**

For more details circle #451 on mailing card.

Ditto Masterfax Performs Four Functions

Four important duplicating functions can be performed on the new Ditto Masterfax. It will make Direct (Spirit) Process masters, offset masters and facsimile copies, and will also laminate. No carbon is required in typing or preparing masters as

material to be duplicated is typed, written or drawn on a clean white Masterfax sheet which is then inserted into the machine. Direct Process masters can also be made from original copy. Inexpensive facsimile copies of most original material is easily made by a dry process on any weight of paper. Laminating is done without complicated adjustments. The machine permanently covers cards, clippings and other material with a tough, protective plastic in less than a minute. **Ditto, Inc., 6800 N. McCormick Blvd., Chicago 45.**

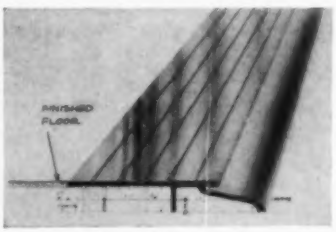
For more details circle #452 on mailing card.

Frozen Fruit Punches Have Lemon Juice Base

Strawberry-lemon, raspberry-lemon, pineapple-lemon and grape-lemon are the new frozen fruit punches introduced by Sunkist. All four flavors have a pure fruit base of lemon juice and no synthetic flavors or colors are added. **Sunkist Growers, 707 W. 5th St., Los Angeles 13, Calif.**

For more details circle #453 on mailing card.

Zero Door Saddle Eliminates Tripping



Specially designed for out-opening doors in schools, hospitals and other institutions where extra safety is important, the Zero non-trip saddle can be fitted with either a flexible hook or an extruded rigid interlock. It is available in extruded bronze and aluminum and is an addition to the complete line of weatherstripping for regular and sliding doors and windows, lightproofing and soundproofing manufactured by **Zero Weather Stripping Co., Inc., 451 E. 136th St., New York 54.**

For more details circle #454 on mailing card.

(Continued on page 182)

Automatic Well Counter Measures Radioactivity

Designed as a nuclear aid in medical and biological research, the Picker Automatic Well Counter measures the radioactivity of up to 100 samples. Test tubes

are individually conveyed over the unit's well-type detector, contents are assayed for radioactivity, and the results are counted, compiled and typed by the count and time printer, all automatically. **Picker X-Ray Corp., 25 S. Broadway, White Plains, N.Y.**

For more details circle #455 on mailing card.

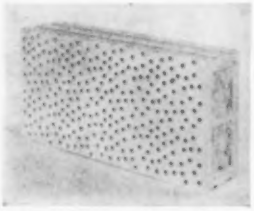
Attractive, Comfortable Chairs Feature Low Cost

Slim, tapered legs with double-tapered rear pillars, posture backs for comfort and rugged balanced construction are built into the new Ten Hundred Line of chairs for patient rooms and reception areas. Nine basic styles and 26 combinations are included in the new line which offers comfort and attractive appearance with low cost and maintenance-free service. **National Store Fixture Co., Inc., Odenton, Md.**

For more details circle #456 on mailing card.

Ceramic Glazed Structural Tile Incorporates Acoustical Control

Combining the principle of a Helmholtz Resonator and cells filled with fiberglass, the new SoundBar Ceramic Glazed Structural Acoustical Tiles offer high sound absorption and efficient sound insulation. They permit the economical construction of all-acoustical load bearing walls. Acoustical panels or random-



acoustical applications may be achieved by using SoundBar acoustical tile in combination with Arketex Straight-Line Ceramic Glazed Structural Tile. SoundBar tile has a distinctive texture and is available in a wide range of New Direction Colors. It has high resistance to moisture and fire, ability to withstand abrasion, affords thermal insulation and is easily cleaned and maintained. **Arketex Ceramic Corp., Brazil, Ind.**

For more details circle #457 on mailing card.

(Continued on page 184)

Need an oven in your LABORATORY

for positive, rapid, long lasting service?

MODEL 288—Positive sterilization for glassware, needles, certain types of instruments. Built to specifications for hospital laboratories. 110-220 Volt A.C. single phase. Available in all sizes. Manual or automatic control.

MODEL 288
Max. temp. 400° F

MODEL 203-2
Maximum temp. 600° F

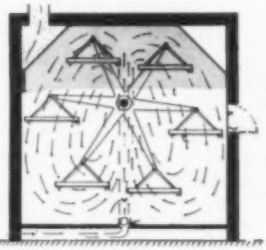
MODEL 203-2—Forced convection oven, precision automatic controlled. Set it and forget it. Controls easily adjusted from front of oven. All working parts accessible from front of oven. High velocity fan provides total circulation throughout work space. Beautiful hammertone grey, enamel exterior. Stainless steel interior.

Write today for complete information and specifications on Despatch Ovens.

for your KITCHEN explore a DESPATCH BAKERY OVEN

Uniform crusting of all bakery products guaranteed with the Despatch Moisture-Master Steam Dome reel type bakery oven. This feature is ideally suited to hospital baking needs. Ovens are available in capacity from 4 to 70 bun pans. Gas, oil or electric heat.

BAKER BOY 12
12 bun pan capacity



MOISTURE MASTER STEAM DOME

(See illustration at left) Steam dome traps moisture in upper third of oven. Each tray passes thru moisture laden area constantly to provide uniform thin brown crusts on baked goods.

Write today for complete information and specifications on Despatch Bakery Ovens.

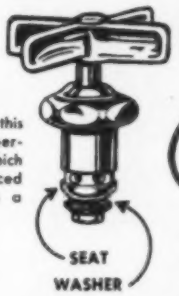
DESPATCH OVEN CO.

DESPATCH OVEN COMPANY

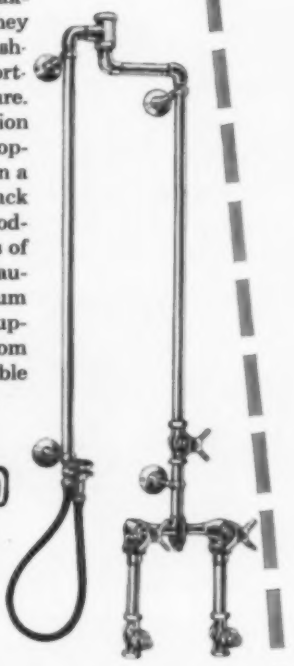
619 S. E. 8th Street • Minneapolis, Minn.

Why Chicago Faucets ask less "time-out" for repairs

Operating records prove it. Chicago Faucets stay leak-free far longer because they close *with* the pressure; washers are spared the life-shortening fight *against* pressure. When they do need attention just lift out the standard operating mechanism, drop in a spare and put the faucet back in service immediately. Products of more than 50 years of specialization, Chicago Faucets promise you maximum service with minimum upkeep. And you choose from the largest selection available of faucets for hospital use.



The secret's in this standard operating unit which can be replaced as easily as a light bulb.



No. 904 Bed Pan Flusher with integral vacuum breaker. Others with concealed piping, different spouts and sprays, etc.

No. 631 Wrist-Operated Wash-up Fixture. Also pedal- and leg-operated types, different spouts, etc.

The Chicago Faucet Co.
2712 N. Pulaski Rd., Chicago 39, Ill.

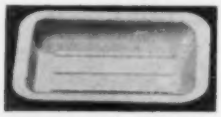
HERE'S HELP—
If you buy or specify faucets for hospital use write for complete catalog . . . or new Sketch Book of engineering data on special faucets.

CHICAGO FAUCETS
Last As Long As the Building

Distributed through the plumbing trade exclusively

Miniature Soap Dish For Use in Limited Space

Fully autoclavable to 275° F., unbreakable, and stain and chemical resistant, Zylon's new MSD-3 Miniature Soap Dish is practical for use in limited space, such



as the compact sink, in patient rooms and other areas. The low-priced, reusable dish, available in white or aqua, holds soap bars with a maximum base of 2½ by 1⅝ inches. **Zylon Products Co., Inc., 40 Church St., Pawtucket, R. I.**

For more details circle #458 on mailing card.

Graham Cracker Crumbs In 25-Pound Bag

Over 60 Graham crumb pies can be made from the new 25-pound sized bag of Nabisco Graham cracker crumbs for institutional use. The crumbs are of high quality crackers uniformly crumbled and are packed in a multi-wall, polyethylene-lined bag for maximum protection. A variety of dessert ideas is available from Nabisco's test kitchens. **National Bisquit Co., 425 Park Ave., New York 22.**

For more details circle #459 on mailing card.

Emergency Exit Window for First-Floor Evacuation

Designed for emergency exit from ground-floor areas, the Lupton Emergency Exit Window is hung on three half-surface hinges that allow the complete window to swing outward 180 degrees from its frame. The aluminum window resembles and can be used with standard projected windows, and offers all the advantages of regular projected ventilator windows, including air-flow directed upward, protection from rain and ease of cleaning. Constructed from heavy extruded aluminum sections, the windows are available in widths from two feet, 11 inches to three feet, four inches, and in heights from four feet, one

inch to five feet, one inch. If desired for uniformity in appearance, the Lupton Emergency Exit Window is also available without projected ventilators or with horizontal muntins. **Michael Flynn Mfg. Co., 700 E. Godfrey Ave., Philadelphia 24, Pa.**

For more details circle #460 on mailing card.

Information Card and Button for Special Patients

Protection can be given epileptic, diabetic, cardiac, allergy and other patients who require special attention in case of emergency with the new "Medical Alert" blank and button. The form is the same size as a dollar bill and provides spaces for all vital information. It is designed to be carried in the wallet and a button stating "Vital medical emergency information in currency section of my wallet" is supplied for attaching to pocket, chain, swim trunk, lingerie or other area where it will be found in emergency. **Medical Alert, 111 S. Madison St., Green Bay, Wis.**

For more details circle #461 on mailing card.

Punching and Plastic Binding Done By Single-Unit Machine

A single-unit punching and plastic-binding machine weighing less than 10 pounds

is added to the American Photocopy line. Called the ComBind Bindak, the unit may be moved from department to department easily and has the added convenience of an operating handle which can be removed and inserted in either side, permitting left or right-handed persons to use the machine. It is finished in brown and beige with chrome-buffed trim, and is economically priced. **American Photocopy Equipment Co., 2100 Dempster St., Evanston, Ill.**

For more details circle #462 on mailing card.

(Continued on page 186)

Matico Vinyl-Asbestos Tile corridor from one of four nursing stations.

MERCY HOSPITAL:

new midwestern medical facility boasts modern marvels and

MATICO TILE FLOORS

Brand-new babies live in a "pediatrics house of glass" . . . medical records and small instrument packets whoosh through pneumatic tubes . . . two-way "talkies" link patients and nurse . . . surgeons dictate post-operative instructions from operating rooms.

In keeping with this new age of medical science at modern Mercy Hospital, Matico Vinyl-Asbestos Tile was selected for its lustrous beauty, its quiet resiliency, its long wear, and its talent for sanitary, easy cleaning with minimum effort.

In the modern plan for your hospital, consider Matico Tile. For full information, write to Matico, Dept. 23-7, P.O. Box #128, Vails Gate, N. Y.

The bright, modern waiting room.

First of two new T-shaped wings for Mercy Hospital, Des Moines, Iowa.

MASTIC TILE DIVISION
The RUBEROID Co.

RUBEROID: Superior Building Products for Better Building

Vinyl Tile • Vinyl-Asbestos Tile • Asphalt Tile • Plastic Wall Tile

Architects and Engineers: Brooks-Borg • General Contractor: Wm. Knudson & Sons, Inc. • Flooring Contractor: Curran Floor Covering

QUALITY CONTROLLED MATICO PRODUCTS

10M814

For additional information, use postcard facing back cover.

Complete Food Center in Self-Contained Cabinet

The Chef "President II" is a complete food center for floor kitchens, nurses

homes and other areas. It is self-contained in a smartly styled cabinet available in natural wood-grain finishes. The unit is made up of a four-cubic-foot refrigerator with a seamless plastic innerliner and large horizontal freezer, and an electric cooking top equipped with 110 or 220-volt mono-tube tilt-up surface units. The work top includes a sink and is one solid piece of stainless steel. **General Air Conditioning Corp., 4542 E. Dunham Rd., Los Angeles 23, Calif.**

For more details circle #463 on mailing card.

Breaded Beef Steak in Four-Ounce Portion

Made of mildly spiced chopped and cubed beef coated with golden breading, the new four-ounce Armour Western Ranch brand steak can be served at a meat portion cost under 20 cents. Providing exact portion control for institutional food service, the steaks are packed 40 to a 10-pound carton, can be removed individually without defrosting the remainder, and are deep-fat fried in three to five minutes. **Armour & Co., P.O. Box 9222, Chicago 90.**

For more details circle #464 on mailing card.

Toilet Tissue Dispenser Holds Big Supply

Three to seven days supply of tissue can be held in the new "Tissue-Master"

dispenser. It is made of durable white plastic with a burnproof chrome top, is quiet in operation and refills easily. When the first roll is finished, the empty core is removed and the second roll automatically drops into place. The plastic and chrome construction facilitates maintenance, resists rust and never requires painting. **Steiner Co., 740 Rush, Chicago, 11.**

For more details circle #465 on mailing card.

Disposable Paper Louvers for Vertical Blinds

A specially treated paper called Parchment, with an off-white mottled texture, is now available for use in vertical blinds. The disposable and relatively inexpensive product makes sanitary draperies for contagious wards and other areas where disposability is an advantage. The paper LouverDrape Verticals are treated for flame resistance. **Vertical Blinds Corp. of America, 1936 Pontius Ave., Los Angeles 25, Calif.**

For more details circle #466 on mailing card.

Stick-On Litter Bag Is Fire Retardant

Made of green flame-resistant paper, the stick-on litter bag for attaching to the

bed beside the patient, is six by three and one-half by eleven inches in size. The patented tuck-in flaps assure a wide opening for easy use and for closing when filled. A self-stick patch is attached to the bag for easy application where desired without damage to the surface. **Klean Kan Bag Co., 64 E. Eighth St., New York 3.**

For more details circle #467 on mailing card.

Three Water Coolers Added to Westinghouse Line

A low-priced, standard, four-gallon per hour, air cooled pressure type cooler, Model W4C, developed especially to meet the needs of locations with moderate traffic, is an addition to the Westinghouse line of water coolers. Two new "wall-hung" units are the seven-gallon per hour Model WL7D and the 11-gallon per hour WL11D, both of which have fan cooled, finned tube condensers and hand actuated bubblers, and can be installed flush to the wall with all plumbing concealed.

Westinghouse Electric Corp., 300 Philipi St., Columbus, Ohio.

For more details circle #468 on mailing card.

M-2 Castile Enema Soap Makes Quart of Solution

Packaged ready for use, the M-2 Castile Enema Soap unit makes a quart of pure soap solution instantly without measuring, mixing or waiting. Time is saved, purity ensured and uniform dosage ready for administration. Developed at the request of hospitals and with the cooperation of the nursing staff, the M-2 formulation was tested and shown safe, effective, convenient and economical in hospital use. **Erlen Products Co., 700 S. Flower St., Burbank, Calif.**

For more details circle #469 on mailing card.

Dollar Bill Changer for Vending Installations

Operating on electronic principles, the new Bill Changer accepts a one dollar bill, checks it and in four seconds returns change, the combination of which is controlled by the operator. While accepting wrinkled, crumpled, stained or marked money, whether inserted upside down or

reversed, the machine will reject foreign currency or fake money of all kinds. The practical dollar Bill Changer facilitates the use of all vending equipment and eliminates the bother of change making by adjacent cashiers. **A. B. T. Div., Atwood Vacuum Machine Co., Rockford, Ill.**

For more details circle #470 on mailing card.

(Continued on page 188)

Parallel-O-Grey Mirropane for Special Area Viewing

Mirropane, the transparent mirror which permits observation without being seen, is now available in a new form for use in areas where there is little difference in light intensity between the two rooms involved. Known as Parallel-O-Grey Mirropane, the product consists of a special chrome alloy, thin enough to be transparent, applied to the special twin-ground gray glass by thermal evaporation. When viewed from one side, Mirropane appears as a mirror, but is transparent from the opposite, depending on the relative strength of the light in the two areas it separates. With the new product, positive effectiveness is obtained with a low light ratio, permitting its use in many areas which have light conditions unsatisfactory for regular plate Mirropane. The product is particularly valuable for observation of mental patients and in other areas of the hospital. **Libbey-Owens-Ford Glass Co., 811 Madison Ave., Toledo 3, Ohio.**

For more details circle #471 on mailing card.

Non-Allergic Aloline Pillow Waterproof and Autoclavable

Softex, a vinyl coated rayon with a cloth-like texture, forms the covering of the new Aloline waterproof pillow. Filled with Celafil, a synthetic, non-allergic, resilient, soft, cool, white, odorless, dustless, mildew and rot-proof material, the

pillow is fully autoclavable and can be sponged off or washed with a wet sterilizing agent. The new product promotes sanitation and has an increased life, since the ticking cover is soil and stain-resistant. **A. S. Aloe Co., 1831 Olive St., St. Louis 3, Mo.**

For more details circle #472 on mailing card.

Stainless Steel Hardware for Patient Room Door Control

Of strong, clinically clean stainless steel, Glynn-Johnson hardware for patient room door control is impervious to tarnish, corrosion and rust. Included in the complete door control combination are an overhead friction holder which holds the door open at any degree at which it is set until manually moved, two combination hand and arm pulls mounted on either side of the door and convenient for opening and closing it when hands are sterile or when carrying trays, and roller latch and rubber door silencers which prevent latch "clicking" and door slamming noise. **Glynn-Johnson Corp., 4422 N. Ravenswood Ave., Chicago 40.**

For more details circle #473 on mailing card.

Low-Priced Change Sorter-Counter Is Readily Portable

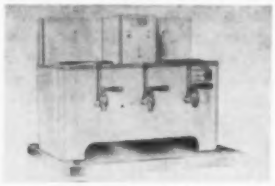
Light weight and low price are features of the new combination coin counter and sorter recently introduced by Standard Change-Makers. After the operator sets the counter and flips the switch, he pours in the coins which the electric machine automatically counts speedily and accurately. Sorting and counting operations are separate, providing an automatic check

of the total. The precision-built machine weighs just 27 pounds and is readily carried to the place of need in its Hammerloid Brown finished, sturdy carrying case. It operates on 110 volts A.C. **Standard Change-Makers, Inc., 422 E. New York St., Indianapolis 2, Ind.**

For more details circle #474 on mailing card.

Electronic Coffee Maker Makes 12 Cups in Three Minutes

The Best Bottle Brewer, an electronic coffee maker designed for small volume coffee service, is used as an auxiliary brewer in floor kitchens, service areas or snack bars. Connected to the cold or hot water line, the machine makes 12 cups of coffee in three minutes and water flow and shut-off are automatically controlled.

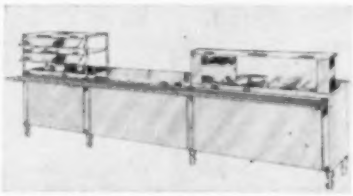


The complete unit includes two 12-cup decanters and a stainless steel extractor, is available in a choice of attractive finishes and requires less than 1½ square feet of space. **Best Products Co., 2620 W. Addison St., Chicago 18.**

For more details circle #475 on mailing card.

Cafeteria Counter Priced Lower For Limited Budgets

Mass production methods and technics make possible the low cost of the new Aerohot all-stainless steel cafeteria counter, priced within the range of food service operators who must work with a limited budget. Rigid construction provides the counter with durability, minimum maintenance and ease of cleaning,



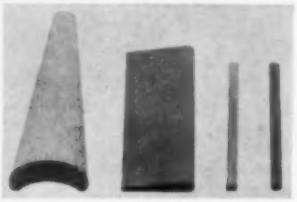
while a choice of hot food, solid top, cold pan, urn stand, skeleton and tray stand units in various sizes permits flexibility of use. **Duke Mfg. Co., 2305 N. Broadway, St. Louis 6, Mo.**

For more details circle #476 on mailing card.

(Continued on page 190)

Instrument Hones In Set of Four

Four instrument hones are now available as a set in a case, or individually. The carefully selected hones include a gouge stone, a wedge slip stone, a square India stone and a round India stone, pro-



viding for every need. **Zimmer Mfg. Co., Warsaw, Ind.**

For more details circle #477 on mailing card.

Disposable Lancet of Type 430 Stainless Steel

Type 430 stainless steel is now used to form the sterile disposable blood lancets distributed by Propper. The stainless steel resists corrosion, is easily made sterile and remains so under proper storage conditions. The lancets are produced and packaged economically enough to permit them to be discarded after one use, preventing the possibility of cross infection. **Propper Mfg. Co., Inc., 10-34 44th Drive, Long Island City 1, N.Y.**

For more details circle #478 on mailing card.

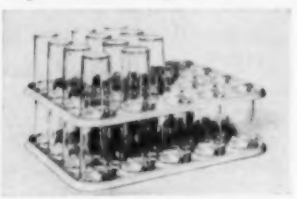
"Free Floating" Panels In Portable Room Divider

A new "free floating" panel, set within full-length aluminum channels or channel clips which are attached to the inside of the frame of the Barricks portable room dividers, allows expansion or contraction without buckling or warping, even under the most severe humidity changes. The room dividers are available in a wide range of panels, including plain hardboard, pegboard, chalkboard, cork bulletin board and a combination of chalkboard and bulletin board. **Barricks Mfg. Co., Dept. H-3, 134 W. 54th St., Chicago 9.**

For more details circle #479 on mailing card.

Stak-A-Glas Trays of High Impact Plastic

The Silite Stak-A-Glas trays of high impact plastic hold 20 glasses, stack safely



one on top of another for storing in small space, and prevent glasses from chipping or breaking. Featuring ridge and groove construction, which allows air to circulate between glasses so they dry while stored, the new trays may be washed in commercial dishwashers and are resistant to mild acids, alkalis and staining. **Silite, Inc., 2600 N. Pulaski Rd., Chicago 39.**

For more details circle #480 on mailing card.

(Continued on page 192)

New Steel Bookcases Feature Sliding Shelves

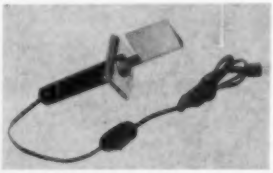
The new Lyon Adjustable Steel Bookcases feature sliding shelves on 1½-inch

centers that are adjusted or removed instantly by lifting the front edge and pulling, but lock firmly in position when relocated. Manufactured in two sizes, a two-shelf desk-high model with a rounded front edge on top, and a seven-shelf library model with a cornice top, the bookcases are finished in gray baked-on enamel. They may be used individually or fastened together in continuous rows and are suitable for open shelf filing. **Lyon Metal Products, Inc., 2 Plant Ave., Aurora, Ill.**

For more details circle #481 on mailing card.

Tissuemat Knife Has Heater in Handle

The sectioning of embedded tissue is facilitated with the new Fisher Tissuemat Knife which contains a one-piece ceramic-cast heating element built into the beryllium-copper blade. The knife is plugged in, turned on and heats to a continuous 82 degrees C for sectioning. Valuable for isolating tissues, scoring the embedding tray, separating individual blocks of Tissuemat, trimming the blocks, and heating the mounting-pedestal face, the knife is also useful for severing ribbbon sections in selecting the particular samples to be slide-mounted. Easy to wield and with a sure grip, the handle remains cool because it is separated from the blade by a com-



bination Formica heat-shield and aluminum name-plate which provides thermal insulation and serves as a knife stand. **Fisher Scientific Co., 717 Forbes St., Pittsburgh 19, Pa.**

For more details circle #482 on mailing card.

Square Twin Coffee Urns Fully Redesigned

The completely redesigned line of square twin coffee urns by Seco is available in three and five-gallon capacities, in both the thin line and the short line styles. A stainless steel lock screw in the bottom of the liner is removed to permit the entire assembly to be lifted out for easy cleaning of lime deposits or sedimentation. Liners are of one-piece, deep drawn stainless steel and the entire body has all seams welded. Both gas and electric models are included in the line which can be kept spotlessly clean with minimum effort. **Seco Company, Inc., 4560 Gustine Ave., St. Louis 16, Mo.**

For more details circle #483 on mailing card.

Transportable Oxygen Unit Draws Gas From Atmosphere

Practical for use in hospitals and ambulances, a transportable oxygen unit called AerOxy-Gen draws air from the atmos-

phere, filters out contaminants, extracts oxygen and delivers the gas at approximately five pounds per square inch pressure in less than one minute after activation. About two feet square, the device weighs 150 pounds, eliminates the need for heavy steel supply cylinders, requires only ordinary current and is operated by a single switch. The unit can be used on a moving vehicle as it is not influenced by vibration or position. **Aerojet-General Corp., Azusa, Calif.**

For more details circle #484 on mailing card.

Two-Bubbler Unit Available in Colors

Haws Model 10F, a fiberglass multiple wall drinking fountain with two bubblers, is available in a selection of permanently bonded decorator colors. Featuring the same flowing lines as the Model 10Y three-bubbler unit that has been available for two years, the new fountain has two chrome plated brass angle stream fountain heads mounted on a receptor of vacuum molded, lightweight fiberglass plastic. **Haws Drinking Faucet Co., 4th & Page Sts., Berkeley 10, Calif.**

For more details circle #485 on mailing card.

Recessed Air Diffuser in Day-Brite Light Troffer Unit

Research facilities of Barber-Colman and Day-Brite Lighting cooperated to develop a recessed air diffuser with an enclosed light troffer unit. The new diffuser is available in one by four-foot and two by four-foot sizes, and two, three or four fluorescent tubes. Slots along both sides of the light fixture carry engineered air distribution for year-round air conditioning. Air volume is controlled by a five-foot expanding cone damper which is accessible by unlatching the bottom of the diffuser. Discharge air is completely separated from ballasts, fluorescent tubes and reflecting surfaces. The Mobilex light fixture and air diffuser is available from **Barber-Colman Co., 1300 Rock St., Rockford, Ill.**

For more details circle #486 on mailing card.

Hospital Bedlight Has Two Light Levels

Featuring the warmth and beauty of natural wood coupled with adjustable illumination especially geared to the needs

of both the patient and the hospital staff, the Lam Hospital Bedlight provides a choice of two light levels, a broad source of light for reading and a lower level for conversation or resting. The lamp has an open construction which permits light to bathe the walls evenly and without glare, and a swivel-mounted wood shield directs light upwards out of the eyes of the patient or downwards to increase the illumination available for examinations. **Lam Inc., 404 Main St., Wakefield, Mass.**

For more details circle #487 on mailing card.

Foot Operated Soap Dispenser For Pre and Post-Operative Scrubbing

Developed for the "wash and scrub" procedure of doctors and surgeons, the all-plastic Ped-O-Flo is a foot operated surgical soap dispenser economical for installation at scrub sinks and lavatories. The dispensing unit is attached to the wall and is connected to the foot bellow positioned beneath the lavatory by a small gray rubber tube. When the foot bellow is depressed, liquid surgical soap is ejected in a prescribed amount regulated by means of a stainless steel needle valve. The one-quart soap container is of polyethylene with a large top opening for easy re-filling, the wall housing is of white phenolic plastic with rounded surfaces, and the no-drip stainless steel nozzle is designed so that soap will not harden within it or cake on its tip. The unit can also be used to dispense alcohol. **Peck's**

Products Co., 610 E. Clarence Ave., St. Louis 13, Mo.

For more details circle #488 on mailing card.

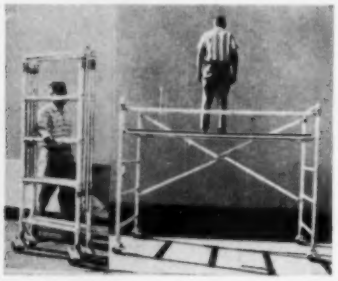
(Continued on page 194)

Liquid Rug Shampoo For "On Location" Cleaning

A new, semi-thick, clear, synthetic liquid Rug Shampoo is effective and fast-acting in the cleaning of wool, cotton, synthetic and blended carpeting and fabrics, and has been formulated for "on location" cleaning of carpeting and rugs as well as upholstery. When diluted with water the cleanser forms billows of suds made up of tiny bubbles which penetrate and clean without soaking or fading the fabric. The shampoo, available in 5-gallon steel containers, contains mildew-preventive and fire-retardant agents. **J. I. Holcomb Mfg. Co., Inc., 1600 Barth Ave., Indianapolis 7, Ind.**

For more details circle #489 on mailing card.

One-Piece Aluminum Scaffold Wheels and Unfolds Quickly



Ready mobility to place of use and unfolding in seconds almost automatically are features of the Up-Right V-X Scaffold which make it practical for most maintenance uses. The one-piece scaffold rolls on wheels for one-man handling. Two folding V braces snap together and lock automatically to form a rigid X brace joint to support the structure when open. It is ten feet long and 29 inches wide for easy rolling through doorways and down narrow aisles. The platform height is adjustable from one to 8½ feet. Legs adjust instantly for uneven floors and stairways and the casters lock automatically for rigidity. The V-X occupies minimum space in storage, folding into a 9½ inch thick package. **Up-Right Scaffolds, 1013 Pardee, Berkeley, Calif.**

For more details circle #490 on mailing card.

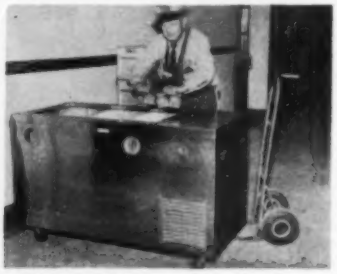
Positive Vacuum System in Statler-Petoskey Floor Sander

A powerful new type vacuum system that pulls all sanded particles into a bag without dust, is a feature of the new Statler-Petoskey Floor Sander. No edging equipment is needed as the machine sands flush with moldings. The twin sanding pads are reversible and easily snapped off. The sander is easy to operate, can be carried, and the functional design permits the handle to be swung to either side in use. **Statler-Petoskey Corp., 20356 Grand River Ave., Detroit 19, Mich.**

For more details circle #491 on mailing card.

Mobile Milk Dispenser Handles Cartons or Bottles

Three independent elevators dispense cartons or glass containers of milk at serving height in the new Lincoln mobile milk unit. The refrigerated, self-contained dispenser requires no drain connection and is constructed of stainless steel. It stores up to 985 half pints of milk and is easily wheeled to any desired location. **Lincoln Mfg. Co., Inc., P.O. Box 2313, Fort Wayne, Ind.**



For more details circle #492 on mailing card.

(Continued on page 196)

Pharmaceuticals

Maxipen

A mixture of the D and L isomers of alpha-phenoxyethyl penicillin potassium, Maxipen is a new synthetic oral penicillin said to produce blood serum levels about twice as high as oral penicillin V and its potassium salt, and higher than injectable procaine penicillin G. It is indicated in the treatment of many penicillin-susceptible infections and is supplied in bottles of pink scored tablets and as a dry powder in 60 cc. bottles for reconstitution with water to produce a red-colored, fruit-mint flavored oral solution. **J. B. Roerig & Co., 800 Second Ave., New York 17.**

For more details circle #493 on mailing card.

Furacin-HC Cream

Furacin and hydrocortisone acetate in a vanishing cream base are the components of Furacin-HC Cream, useful in the treatment of both acute and chronic cutaneous conditions where infection is present or imminent. The cream, applied topically, is supplied in 5 and 20 gm. tubes and combines the potent antibacterial action of Furacin with the anti-inflammatory and anti-pruritic effect of hydrocortisone. **Eaton Laboratories, 17 Eaton Ave., Norwich, N.Y.**

For more details circle #494 on mailing card.

Geriliquid

Geriliquid is a new preparation designed to produce sustained warming of cold hands and feet through the thermogenic action of the amino acid glycine and through long-term vasodilatation by glycine and the vitamin niacin. It is indicated for treatment in conditions associated with impaired peripheral circulation and supplied in bottles of eight fluid ounces. **Lakeside Laboratories, Inc., 1707 E. North Ave., Milwaukee 2, Wis.**

For more details circle #495 on mailing card.

Dianabol

A new tissue-building drug, Dianabol, converts protein to working weight and improves appetite, strengthens skeletal structure and renews vigor in underweight, devitalized patients. For use whenever weight loss poses a medical problem, Dianabol is of special value to elderly people suffering from geriatric malnutrition and chronically ill and convalescent patients, and is supplied in bottles of 100 5 mg. scored tablets. **Ciba Pharmaceutical Products Inc., Summit, N.J.**

For more details circle #496 on mailing card.

Isogesic Rx

Isogesic Rx is a decongestant-antihistamine-analgesic indicated for treatment of influenza and the common cold. It provides an effective nasal and bronchial decongestant, a histaminic blocking agent and two synergistic analgesics and antipyretics for relief from muscular aches and pains and headache of sinus or allergic origin. **Arnar-Stone Laboratories, Inc., 225 E. Prospect Ave., Mount Prospect, Ill.**

For more details circle #497 on mailing card.

Tenuate

An appetite-suppressing prescription drug, Tenuate is indicated for use in hunger control of problem cases, to bring about satisfactory weight loss. It does not get rid of fat or excess tissue by itself, but dulls the desire for food. Tenuate is dispensed in 25 mg. tablets. **The Wm. S. Merrell Co., Cincinnati 15, Ohio.**

For more details circle #498 on mailing card.

Literature and Services

• Kewanee forced draft square-heat packaged boiler-burner units for oil, gas or combination firing are described and illustrated in a new four-page bulletin, **Form No. 1145,** available from American-Standard Industrial Div., Detroit 32, Mich.

For more details circle #499 on mailing card.

• **"More Kimble Laboratory Ware With Teflon Stopcock Plugs"** is the title of **Catalog Supplement SP-63** released by the Kimble Glass Co., Owens-Illinois, Toledo 1, Ohio. Factual information on the new Kimble Teflon stopcock and its uses is included with data on many varieties of laboratory ware.

For more details circle # 500 on mailing card.

• **"How to Reduce Painting Costs"** is the title of a new 12-page illustrated guide to economical maintenance painting. Available from Barreled Sunlight Paint Co., 12 Dudley St., Providence 1, R.I., the booklet offers suggestions for savings on labor and materials and outlines many painting economy facts.

For more details circle #501 on mailing card.

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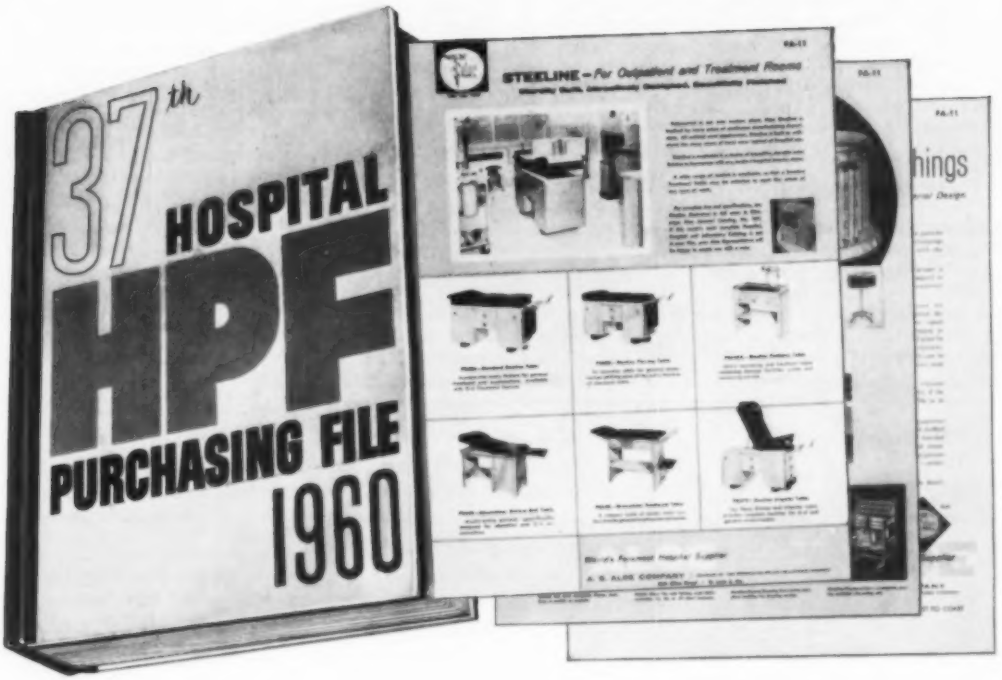

12 pages of ALOE hospital equipment right on your desk

In the 1960 Edition of Hospital Purchasing File on your desk you will find a 12-page catalog of A.S. Aloe Company metal furnishings especially designed for hospitals. The items include examining tables, nurses station equipment, patient room furnishings, surgery and nursery equipment, and cabinets, all lavishly illustrated and described in detail. Aloe has made it easy to find its products by filing this excellent catalog in Hospital Purchasing File where, with 213 other suppliers' catalogs, it helps you save time when you seek product information. Here is a big, useful file of hospital products arranged for easy finding, easy comparison. Be sure to use Hospital Purchasing File. Be sure your department heads learn to use it, too.

• A revised **booklet, NM-601**, available from National Cylinder Gas Div., Chemetron Corp., 840 N. Michigan Ave., Chicago 11, contains instructions and standards for installation of oxygen and nitrous oxide pipe systems. Prepared especially for hospitals and piping contractors, it includes an up-to-date reprint of important parts of the National Fire Protection Association pamphlet No. 565.

For more details circle #502 on mailing card.

• The many uses of the Caddy for handling dishes, food trays, cups and glasses are featured in a four-page catalog entitled **"Versatility in the Caddy Line."** The leaflet, available from Caddy Corp. of America, Secaucus, N.J., describes suggested layouts incorporating the new lightweight plastic stacking cup and saucer trays, and includes photographs, graphic illustrations of total capacities and specifications.

For more details circle #503 on mailing card.

• Various types of **Mail Handling Equipment** are described and illustrated in a new catalog available from Cutler Mail Chute Co., Rochester, N.Y. The 12-page booklet describes mail chutes, mail boxes, lock type letter boxes and mail room equipment, with typical specifications and advantages of the various models.

For more details circle #504 on mailing card.

• A 32-page **Buying Guide to Hospital Apparel** gives evidence of the trend toward interest in appearance without any sacrifice of practicality, and features such innovations as patient gowns in blue seersucker and those that fasten with Velcro. Dresses, coats, smocks and other hospital and operating room garments in a wide range of materials are described, and the catalog, available from Angelica Uniform Co., 1427 Olive St., St. Louis 3, Mo., includes a selection of accessories such as binders and sheets.

For more details circle #505 on mailing card.

• An eight-page brochure entitled **"Emergency Power for Hospitals"** is illustrated in color and contains a chart that describes each generator set manufactured by GM Diesel. The booklet, which pictures several hospital installations, may be obtained from General Motors Corp., GM Diesel Div., Detroit 28, Mich.

For more details circle #506 on mailing card.

• How Armstrong's new fire protective acoustical ceiling tile, Acoustical Fire Guard, saves time and money in institutional construction where rated fire protection is required is the subject of discussion in a new 12-page booklet available from Armstrong Cork Co., Lancaster, Pa. Entitled **"The First Acoustical Ceiling Tile to Offer Rated Fire Protection,"** the booklet cites time saved in construction when Acoustical Fire Guard is used and uses case histories to prove the points mentioned.

For more details circle #507 on mailing card.

• **The Wittenborg "400,"** a vending machine that can dispense anything from toothpaste to a full meal, is described in a folder, **"The Major Advance in Automatic Selling,"** available from Wittenborg, Inc., 169 Gardner Ave., Brooklyn 37, N.Y. The "400" permits variety, making it possible to vend up to 12 selections at different prices from one machine. It will hold as many as 12 adjustable shelves which can be raised or lowered to accommodate the varied sizes of the items to be dispensed.

For more details circle #508 on mailing card.

• A four-page brochure gives factual information on **sickle bar mowing equipment** manufactured by Jari Products, Inc., 2970 Pillsbury Ave. S., Minneapolis 8, Minn. Descriptive information on mowers for cutting heavy grass, weeds and brush, as well as those that can be converted with attachments for year-around maintenance, including snow throwers, is included.

For more details circle #509 on mailing card.

• **Catalog 97** illustrates and describes the line of toilet compartments, shower stalls and hospital cubicles manufactured by Sanymetal Products Co., Inc., 1676 Urbana Rd., Cleveland 12, Ohio. The 32-page booklet includes architectural specifications; information on new types of urinal screens; a description of the new Sanyvinyl-Metal finish; details of engineering developments, and a page of chips showing the colors available.

For more details circle #510 on mailing card.

• **"How to Get the Most Out of Ultrasonic Cleaning"** is discussed in a Service Bulletin available from Oakite Products, Inc., 19 Rector St., New York 6.

For more details circle #511 on mailing card.

INDEX TO ADVERTISEMENTS

USE THIS PAGE TO REQUEST PRODUCT INFORMATION

The index on this and the following page lists advertisements in this magazine alphabetically by manufacturer. For additional information about any product or service advertised, circle the manufacturer's key number on the detachable postcard and mail it. No postage is required.

Products described in the "What's New" pages of this magazine also have key numbers which appear in each instance following the description of the item. For more information about these items, circle the appropriate numbers on the postcard and mail it, without postage, to The Modern Hospital.

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USE THIS CARD — (We pay the postage)

I am interested in the items circled — **July, 1960**

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FIRST CLASS
PERMIT NO. 137
CHICAGO, ILL.

BUSINESS REPLY MAIL
No Postage Stamp Necessary If Mailed in the United States

POSTAGE WILL BE PAID BY

THE MODERN HOSPITAL
919 NORTH MICHIGAN AVENUE
CHICAGO 11, ILLINOIS

for distinctive

low-cost exteriors...

RS ceramic tile

curtain wall panels

There are ever so many reasons for the rapid growth of insulated RS panels as an exterior finish for all types of buildings.

BEAUTY. Choose from solid colors, random mixtures or custom patterns—literally thousands of color and design combinations—to achieve any desired architectural effect. RS panels may be used alone or in harmonious combination with any conventional exterior finish.

PERMANENCE. RS panels are faced with certified frost-proof Romany-Spartan ceramic tile. Time-tested design and rigid quality controls assure trouble-free performance for a building lifetime.

FASTER ERECTION. RS panels are custom-made to your exact specifications and delivered to job-site in light-weight, easy-to-handle units, ready for simple, speedy installation.

LOW LIFETIME COST. The favorable unit price, low installation cost and maintenance-free characteristics of RS panels are your assurance of extra value—"lowest lifetime cost".

CONSULT YOUR ARCHITECT. He'll be glad to provide more information. If you're interested in the technical details, write for Bulletin RSP-201. Ceramic Tile Panels, Inc., Dept. MH-14, Canton 2, Ohio.

The new Grand Traverse Medical Care Facility features RS curtain wall panels of unglazed Romany-Spartan ceramic mosaics, in a pre-selected random pattern.

Plate No. 2001

GRAND TRAVERSE MEDICAL CARE FACILITY
Traverse City, Mich.

Architects:
HARFORD FIELD & ASSOC.
Traverse City, Mich.

Panels installed by:
C. D. BARNES ASSOC., INC.
Grand Rapids, Mich.

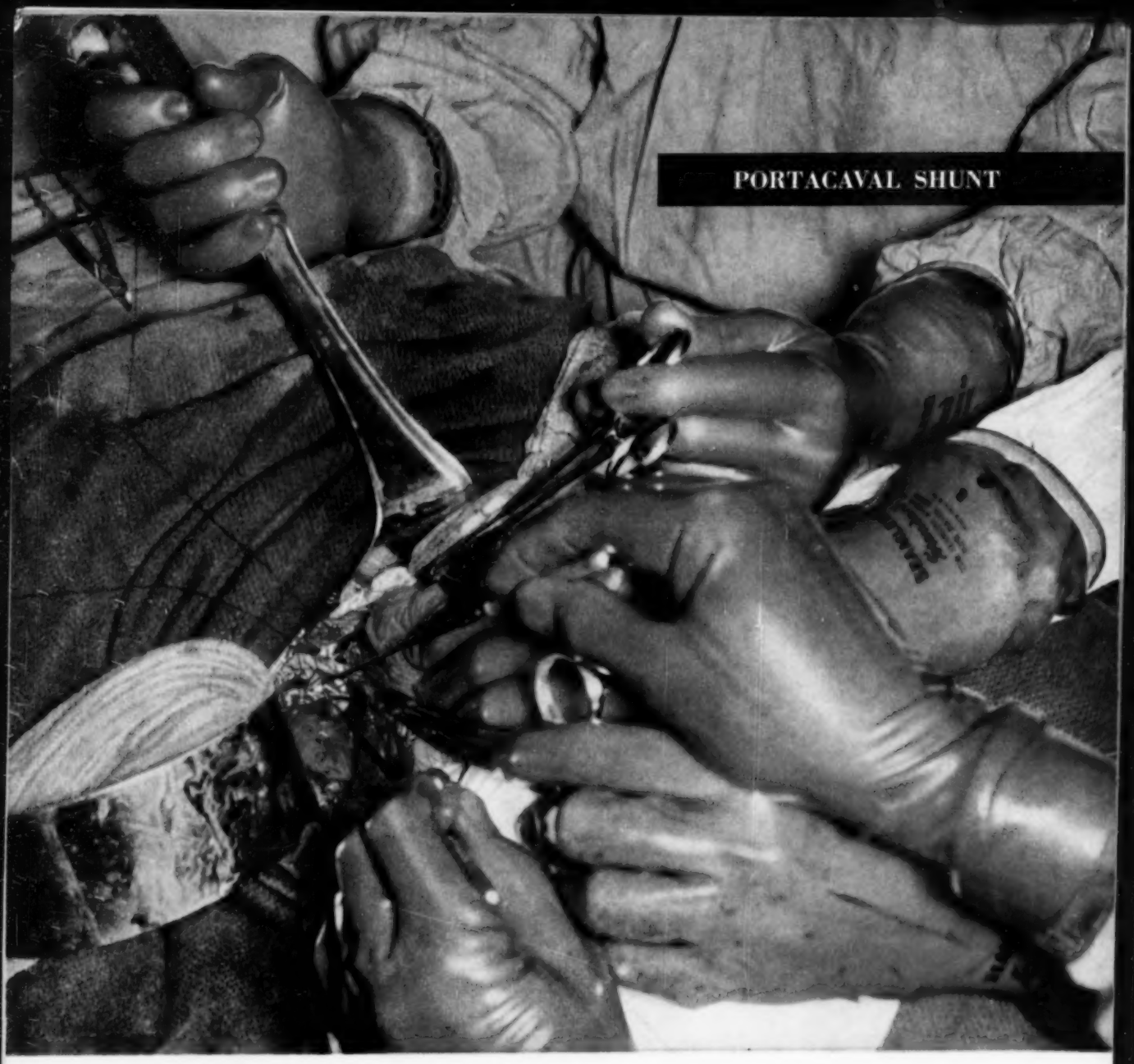
MEMBER

ROMANY · SPARTAN

RS Panels

CERAMIC TILE PANELS, INC.

A subsidiary of United States Ceramic Tile Co.



Make the Surgeon's Task Easier

Brown Milled Surgeons' Gloves by SEAMLESS

Before you order surgical gloves again, consider these facts. Deep in an incision, the maximum tactile sensitivity of Brown Milled Surgeons' Gloves by Seamless assure unmatched "sightless seeing." Minimal radial bind across the knuckles and palm guarantees maximum comfort. Equally important, their hypoallergenic property eliminates the possibility of latex dermatitis. These advantages make Brown Milled Gloves the finest general surgeon's glove available today. Contact your Seamless representative for further information and samples.

HOSPITAL DIVISION

THE SEAMLESS RUBBER COMPANY

NEW HAVEN 3, CONN., U.S.A.